SERFF Tracking Number:	*MEIC-127346142*	*State:*	*Illinois*
Filing Company:	*Medicus Insurance Company*	*State Tracking Number:*	*MEIC-127346142*
Company Tracking Number:	*MIC MANUAL - 07/2011 RULE*		
TOI:	*11.2 Med Mal-Claims Made Only*	*Sub-TOI:*	*11.2000 Med Mal Sub-TOI Combinations*
Product Name:	*MIC Rate Manual - 07/2011*		
Project Name/Number:	*IL Rate Manual 07/2011/IL RM 07/2011*		

Filing at a Glance

Company: Medicus Insurance Company

Product Name: MIC Rate Manual - 07/2011	SERFF Tr Num: MEIC-127346142	State: Illinois
TOI: 11.2 Med Mal-Claims Made Only	SERFF Status: Closed-Withdrawn	State Tr Num: MEIC-127346142
Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations	Co Tr Num: MIC MANUAL - 07/2011 RULE	State Status:
Filing Type: Rule		Reviewer(s): Gayle Neuman
	Author: Jane Cundiff	Disposition Date: 08/17/2011
	Date Submitted: 08/01/2011	Disposition Status: Withdrawn
Effective Date Requested (New): On Approval		Effective Date (New): 08/16/2011
Effective Date Requested (Renewal): On Approval		Effective Date (Renewal):

State Filing Description:

General Information

Project Name: IL Rate Manual 07/2011	Status of Filing in Domicile:
Project Number: IL RM 07/2011	Domicile Status Comments:
Reference Organization:	Reference Number:
Reference Title:	Advisory Org. Circular:
Filing Status Changed: 08/17/2011	
State Status Changed:	Deemer Date:
Created By: Jane Cundiff	Submitted By: Jane Cundiff

Corresponding Filing Tracking Number:

Filing Description:

Please review the updated Medicus rate/rule manual which includes a clarification of how Medicus calculates tail under the Extended Reporting Endorsement. The change in wording now states “for Second Year and all years of maturity, it is applied to the last year’s (365 days) annualized premium from the date of cancellation.”

We also updated the Premium Payment Policy in Section 1 stating the new payments options for the insured.

An edition date was updated to 07/2011 as well and general formatting changes were made.

A copy of the manual with the changes tracked is included in this filing.

Please let us know if we need to provide any further information.

SERFF Tracking Number:	*MEIC-127346142*	*State:*	*Illinois*
Filing Company:	*Medicus Insurance Company*	*State Tracking Number:*	*MEIC-127346142*
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Product Name:	*MIC Rate Manual - 07/2011*		
Project Name/Number:	*IL Rate Manual 07/2011/IL RM 07/2011*		

Thank you, Jane Cundiff

Company and Contact

Filing Contact Information

Jane Cundiff, Regulatory Ccmpliance Coordinator
4807 Spicewood Springs Road
Bldg 4-100
Austin, TX 78759

jcundiff@medicusins.com

512-879-5128 [Phone]

Filing Company Information

Medicus Insurance Company
4807 Spicewood Springs Rd, Bldg. 4 1st Floor
Austin, TX 78759

(866) 815-2023 ext. [Phone]

CoCode: 12754
Group Code: 11
Group Name: Property and Casualty
FEIN Number: 20-5623491

State of Domicile: Texas
Company Type:
State ID Number:

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Medicus Insurance Company	$0.00		

State Specific

Refer to our checklists prior to submitting filing (http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm).: OK
Refer to our updated (04/06/2007) SERFF General Instructions prior to submitting filing. They have been updated to clarify what rates and rules are required to be filed as well as what rates and rules are not required to be filed. Also, the "Product Name" is the Filing Title and not the Project Number.: OK
NO RATES and/or RULES ARE REQUIRED TO BE FILED FOR LINES OF COVERAGE SUCH AS COMMERCIAL

AUTO (except taxicabs), BURGLARY AND THEFT, GLASS, FIDELITY, SURETY, COMMERCIAL GENERAL LIABLITY, CROP HAIL, COMMERCIAL PROPERTY, DIRECTORS AND OFFICERS, ERRORS AND OMMISSIONS, COMMERCIAL MULTI PERIL just to mention a few. However, a Summary Sheet (RF-3) is required to be filed. Please refer to the State Specific Field below for what rates/rules are required to be filed and to our checklists for specific statutes, regulations, etc. : http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm: OK

Medical Malpractice rates/rules may only be submitted in paper.: OK

The only rates and/or rules that are required to be filed are Homeowners, Mobile Homeowners, Dwelling Fire and Allied Lines, Workers' Compensation, Liquor Liability, Private Passenger Automobiles, Taxicabs, Motorcycles and Group Inland Marine Insurance which only applies to insurance involving personal property owned by, being purchased by or pledged as collateral by individuals, and not used in any business, trade or profession per Regulation Part 2302 which says in part, "each company shall file with the Director of Insurance each rate, rule and minimum premium before it is used in the State of Illinois.": OK

When selecting a form filing type for a multiple form filing, use the dominant type from these choices: APP - application; CER - certificate; COF - coverage form; DPS - declaration page; END - endorsement; POJ - policy jacket; ORG - Companies adopting an Advisory or Rating Organization's filing. Example: If you are submitting a policy as well as endorsements, a declaration page and an application, you would select "POL" for policy.: OK

SERFF Tracking Number:	*MEIC-127346142*	*State:*	*Illinois*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Withdrawn	Gayle Neuman	08/17/2011	08/17/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Gayle Neuman	08/02/2011	08/02/2011			

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Withdraw this Filing	Note To Reviewer	Jane Cundiff	08/16/2011	08/16/2011

SERFF Tracking Number:	*MEIC-127346142*	*State:*	*Illinois*
Filing Company:	*Medicus Insurance Company*	*State Tracking Number:*	*MEIC-127346142*
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Project Name/Number:	*IL Rate Manual 07/2011/IL RM 07/2011*		

Disposition

Disposition Date: 08/17/2011
Effective Date (New): 08/16/2011
Effective Date (Renewal):
Status: Withdrawn
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MEIC-127346142*	*State:*	*Illinois*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Explanatory Memorandum		Yes
Supporting Document	Form RF3 - (Summary Sheet)		Yes
Supporting Document	Certification		Yes
Supporting Document	Manual		Yes
Rate	IL Rate Manual 07/2011		Yes

SERFF Tracking Number:	*MEIC-127346142*	*State:*	*Illinois*
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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/02/2011
Submitted Date	08/02/2011
Respond By Date	08/16/2011

Dear Jane Cundiff,

This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:

1. YOU ARE REQUIRED TO COMPLETE THE “COMPANY RATE INFORMATION” ON THE RATE/RULE SCHEDULE TAB.
2. Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used?
3. 215 ILCS 5/155.18 states it shall be certified in this filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience. This information is required in every rate/rule filing for medical malpractice.
4. In regard to the premium payment plans, the manual should indicate there are no interest charges or installment fees if applicable.
5. Company Bulletin CB2011-05 was issued on May 11, 2011 in regard to requirements for schedule rating plans.

Sign up to get e-mail notification for updates to the Department's website. http://insurance.illinois.gov/RSS/

Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:

http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.htm

Please submit compliant form(s) no later than the date shown above or the entire filing may be disapproved. Please be advised that when the Director disapproves the form(s) you must immediately cease using the form(s) in Illinois.

Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.

SERFF Tracking Number:	*MEIC-127346142*	*State:*	*Illinois*
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Sincerely,
Gayle Neuman

SERFF Tracking Number:	*MEIC-127346142*	*State:*	*Illinois*
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Note To Reviewer

Created By:
Jane Cundiff on 08/16/2011 05:19 PM
Last Edited By:
Gayle Neuman
Submitted On:
08/17/2011 08:52 AM
Subject:
Withdraw this Filing
Comments:
Ms. Neuman,

At this time we would like to withdraw this filing.

Thank you,

Jane Cundiff

Rate/Rule Schedule

Schedule Item Status:	Exhibit Name:	Rule # or Page #:	Rate Action	Previous State Filing Number:	Attachments
	IL Rate Manual 07/2011		Replacement		IL Rate Manual 07-2011.pdf IL Rate Manual 07-2011_Changes Tracked.pdf

MANUAL

SECTION I

GENERAL RULES

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS AND NON-PHYSICIAN HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

II. APPLICATION OF GENERAL RULES

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section, with reference thereto.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

III. POLICY TERM

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short term policy period.

IV. LOCATION OF PRACTICE

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. However, should an insured practice in more than one rating territory and/or state, the following rule shall apply. If 10% or less of an insured's practice is in a higher rated territory, we use the lower rated territory. If more than 10% of an insured's practice is in a higher rated territory, we use the higher rated territory.

V. PREMIUM COMPUTATION

A. Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.

V. PREMIUM COMPUTATION (Continued)

B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

VI. FACTORS OR MULTIPLIERS

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

VII. WHOLE DOLLAR RULE

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

A. Any amount involving $.50 or over shall be rounded up to the next highest whole dollar amount; and

B. Any amount involving $.49 or less shall be rounded down to the next lowest whole dollar amount.

VIII. ADDITIONAL PREMIUM CHARGES

A. Prorate all changes requiring additional premium.

B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

IX. RETURN PREMIUM FOR MID-TERM CHANGES

A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.

B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.

C. Retain the Policy Minimum Premium.

X. POLICY CANCELLATIONS

A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:

1. A policy is canceled at the Company's request,

2. the insured no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.

C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

XI. POLICY MINIMUM PREMIUM

1. The applicable minimum premium is determined by the type of health care provider shown on the appropriate Rate Pages.

2. Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

XII. PREMIUM PAYMENT PLAN

The Company offers the insured to pay in full or the following premium payment options:

A. The monthly premium payment plan requires a minimum of 12.5% of the total premium to be paid on or before the inception/renewal date of the policy and the policyholder is billed 10 monthly installments of 8.33% and a final installment of 4.17%.

B. The quarterly payment plan requires a 25% down payment and three installments of 25%.

C. Our Automated Clearing House (ACH) option allows the insured to have 12 equal monthly installments.

XIII. COVERAGE

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverages will be rated under Standard Claims-Made Rates.

XIV. BASIC LIMITS OF LIABILITY

Basic Limits of Liability shall be those shown as applicable to the respective insureds.

XV. LIMITS OF LIABILITY

Individual Limits of Liability will be modified by Increased Limits factors as applicable for the respective insureds and used to develop the applicable premium.

XVI. PRIOR ACTS COVERAGE

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). The retroactive date can be advanced only at the request or with the written acknowledgment of the insured, subject to underwriting.

XVII. EXTENDED REPORTING PERIOD COVERAGE

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.

B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.

C. The premium for the Extended Reporting Period Coverage shall be determined by applying the Extended Reporting Period Coverage rating factors shown in Section III-21, F.

D. Premium is fully earned and must be paid in full within 30 days of the expiration of the policy.

E. The Reporting Period is unlimited.

F. The Insured has 30 days after the policy is terminated to purchase the extended reporting period. The Extended Reporting Endorsement must be offered regardless of the reason for the termination

XVIII. PREMIUM MODIFICATIONS

Schedule Rating

Physicians and Surgeons	+/-50
Healthcare Providers	+/-50

- END OF SECTION I-

SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

1. Professional Corporations, Partnerships and Associations

B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:

1. Are comprised of 2 or more physicians;

2. Are organized as a legal entity;

3. Maintain common facilities (including multiple locations) and support personnel; and

4. Maintain medical/dental records of patients of the group as a historical record of patient care.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Claims-Made Coverage

$1,000,000 Per Claim
$3,000,000 Aggregate

III. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations, limited liability companies, or other entity may be written with a separate limit of liability and shall be computed in the following manner:

The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. In order for the entity to be eligible for coverage, the Company must insure all member physicians or at least 60% of the physician members must be insured by the Company, and the remaining physicians must be insured by another professional liability program acceptable to the company.

III. PREMIUM COMPUTATION (Continued)

Number of Insureds	Percent
1	25%
2-5	12%
6-9	10%
10-19	9%
20-49	7%
50 or more	5%

B. Vicarious Liability Charge

For each member physician not individually insured by the Company, a premium charge will be made up to 30% of the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.

IV. CLASSIFICATIONS

A. Corporations, Partnerships and Associations

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Not otherwise identified as a Miscellaneous Entity.

B. Miscellaneous Entities

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Including the following types of entities:

   a. Urgent Care Center
   b. Surgi Center
   c. MRI Center
   d. Renal Dialysis Center
   e. Peritoneal Dialysis Center

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated under D1 on this page, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III-22.

B. Manual Rates

1. Corporations, Partnerships & Associations Rating Factors

As referenced in III in Section II-2:

See Table in Section II-2. Separate Corporate Limits

0% - Shared Corporate Limits

2. Miscellaneous Entities

Not eligible under this Filing.

C. Policy Writing Minimum Premium

The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of $500.

D. Premium Modifications

1. Schedule Rating—Partnerships & Corporations

Physician & Surgeons	+/- 50%
Health Care Providers	+/-50%

2. Self-Insured Retention Credits - See Section III.V.B

- END OF SECTION II-

SECTION III

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

I. APPLICATION OF MANUAL

This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Physicians/Surgeons and employed or associated non- physician health care providers.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

Claims-Made Coverage

$1,000,000 Per Claim

$3,000,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per physician, surgeon or non-physician health care provider shown in Section III-17 to Section III-20, in accordance with each individual's medical classification and class plan designation.

IV. CLASSIFICATIONS

A. Physicians/Surgeons and Non Physician Health Care Providers

1. Each medical practitioner is assigned a Rate Class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The Rate Classes are found in Section III-10 to Section III-15 of this Manual.

B. Part Time Physicians

1. A physician who is determined to be working 20 hours or less a week may be considered a part time practitioner and may be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner are identified in Section III of this Manual.

2. A Part Time Practitioner may include any practitioner in classes 1 through 8 only, except for Anesthesia and Emergency Medicine as identified in the class plan. The hours reported to the company for rating purposes are subject to audit, at the Company’s discretion.

3. The part time credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

C. Physicians in Training

1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:

   a. First Year Resident (or Intern) - 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.

   b. Resident - various lengths of time depending upon medical specialty; 3 years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.

   c. Fellow - Follows completion of residency and is a higher level of training.

2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.

   a. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. The applicable credit is stated presented in Section III-20.

3. The credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

D. Locum Tenens Physician

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.

2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.

3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

E. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:

    a. Residency;

    b. Fellowship program in their medical specialty

    c. Fulfillment of a military obligation in remuneration for medical school tuition;

    d. Medical school or specialty training program.

2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.

3. A reduced rate will be applied in accordance with the credits shown presented in Section III-20. No other credits are to apply concurrent with this rule.

F. Physician Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the insured's private practice.

    a. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program. Refer to K.5 in Section III-20 to determine the applicable credit.

2. Coverage is available for the private practice of a physician teaching specialist. The coverage will not apply to any aspect of the insured's teaching activities.

    a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.

    b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

    c. No other credits are to apply concurrent with this rule.

d. The applicable percentages are presented on presented in Section III-20.

G. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.

2. This will apply retroactively to the first day of disability or leave of absence.

3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.

4. The credit to be applied to the applicable rate is presented in Section III-20.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in Section III-22, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III-22.

B. Risk Management

1% credit will apply for each Company approved CME hour of risk management completed, up to a maximum of 5% credit per year, or attendance at a Company approved seminar.

C. Deductible Credits

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer up to ($1M/$3M). Deductibles are subject to approval by the

Company based on financial statements to be submitted by the insured and financial guarantees are required. The Company reserves the right to require acceptable securitization in the amount of the per claim and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

1. Individual Deductibles

Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:

INDEMNITY ONLY DEDUCTIBLE PER CLAIM		INDEMNITY AND ALAE DEDUCTIBLE PER CLAIM	
$5,000	2.5%	$5,000	6.5%
$10,000	4.5%	$10,000	11.5%
$15,000	6.0%	$15,000	15.0%
$20,000	8.0%	$20,000	17.5%
$25,000	9.0%	$25,000	20.0%
$50,000	15.0%	$50,000	30.5%
$100,000	25.0%	$100,000	40.0%
$200,000	37.5%	$200,000	55.0%
$250,000	42.0%	$250,000	58.0%

The following Individual Deductibles are available on a Per Claim/Aggregate Basis. Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:

Indemnity Only Per Claim/Aggregate		Indemnity & ALAE Per Claim/Aggregate	
$5000/15,000	2.0%	$5000/15,000	5.5%
$10,000/30,000	4.0%	$10,000/30,000	10.5%
$25,000/75,000	8.5%	$25,000/75,000	19.0%

$50,000/150,000	14.0%	$50,000/150,000	29.5%
$100,000/300,000	24.0%	$100,000/300,000	43.0%
$200,000/600,000	36.0%	$200,000/600,000	53.5%
$250,000/750,000	40.0%	$250,000/750,000	56.5%

2. Group Deductibles

An optional deductible, which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year. When the organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below. Group deductible amounts apply to primary premium up to $1M/3M only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate	Number of Insureds				Maximum Credit
($000)	2-19	20-40	41-60	61-100	
5/15	.020	.018	.015	.012	$10,500
10/30	.038	.035	.030	.024	21,000
25/75	.084	.079	.070	.058	52,500
50/150	.145	.139	.127	.109	105,000
100/300	.234	.228	.216	.196	120,000
200/600	.348	.346	.338	.321	420,000
250/75 0	.385	.385	.381	.368	525,000

The following Group Deductibles are available for Indemnity & ALAE.

Indemnity & ALAE Deductible Per	Number of Insureds	Maximum Credit

Claim/Aggregate					
($000)	2-19	20-40	41-60	61-100	
5/15	.029	.026	.021	.017	$12,750
10/30	.068	.063	.054	.043	25,500
25/75	.119	.112	.099	.082	63,750
50/150	.186	.179	.163	.140	127,500
100/300	.258	.252	.239	.216	255,000
200/600	.396	.394	.385	.366	510,000
250/75 0	.467	.467	.462	.446	637,500

D. Experience Rating

This plan applies to physicians and surgeons medical professional liability risks contained in medical groups. As used in this plan, the term “risk” means the exposures of medical groups which have common management, a common and mutually agreed risk management program or a financial relationship among all members which encourages high levels of quality control and a reduction in liability claims.

On an optional basis, large risks with sufficiently credible loss experience may be loss-rated to develop an appropriate premium. To be eligible for loss rating, a group must have at least for the latest 10-year period and at least $100,000 in estimated annual premium.

The experience period will be the latest completed 10 years. If 10 years are not available, consideration will be given to at least 5 complete years.

Losses are developed to ultimate and trended to cost levels for the proposed policy year. Losses will be capped at $250,000 per loss.

The experience period does not include the 12-month period immediately prior to the effective date of the experience modification.

The experience rating modification is calculated using the following formula:

$$\text{Credibility} \times \frac{\text{Adjusted Actual Loss Ratio} - \text{Adjusted Expected Loss Ratio}}{\text{Adjusted Expected Loss Ratio}} = \text{Experience Mod.}$$

Since the experience rating plan is applied on an individual risk basis, the final impact of these changes varies by individual medical group based on risk size and loss experience by year. As a result, the anticipated overall rate impact due to the changes in the experience rating plan is indeterminable. However, the primary purpose of this plan and the revisions is to more accurately distribute the cost of insurance among eligible insureds.

E. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claim free. A schedule is provided in Section III-20.

F. Individual Risk Rating

A risk may be individually rated by submitting a filing to the Illinois Department of Insurance, in accordance with Section 155.18(b)(4) of the Illinois Insurance Code. The code allows us to modify classification rates to produce rates for individual risks. Modifications of classifications of risks may be based upon size, expense, management, individual experience, location or dispersion of exposure, and shall apply to all risks under the same or substantially the same circumstances or conditions. We must list the standards by which variations in hazards or expense provisions are measured, in order to determine that a specific risk is so different in hazard/expense that it warrants individual rating.

VI. MODIFIED PREMIUM COMPUTATION

A. Slot Rating

1. Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.

2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Underwriting Vice President.

B. Requirements for Waiver of Premium for Extended Reporting Period Coverage.

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. The Reporting Period is unlimited.

C. Blending Rates

A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.

D. Per Patient Visit Rating

1. Standard Claims Made coverage for group practices is available, at the Company’s option, on a per patient visit basis rather than on an individual physician basis. Coverage is provided on a shared or individual physician limit basis.

2. The number of patient visits equivalent to a physician year is 2500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour.

3. The applicable medical specialty rate is divided by the equivalent patient visits resulting in the patient visit rate to be applied to the visits projected for the policy period. The product of the patient visit rate and the projected visits results in the indicated manual premium.

4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.

5. Premium modifications for new physician, part time, teaching, risk management or claim free credit cannot be used in conjunction with this rating rule.

VII. PREMIUM COMPUTATION DETAILS

A. Classifications

1. Applicable to Standard Claims-Made Programs.

2. The following classification plan shall be used to determine the appropriate rating class for each individual insured.

PHYSICIANS & SURGEONS

CLASS 1

Allergy/Immunology
Forensic Medicine
Occupational Medicine
Otorhinolaryngology-NMRP, NS
Physical Med. & Rehab.

Public Health & Preventative Med
Other, Specialty NOC

CLASS 2

Dermatology
Endocrinology
Geriatrics
Ophthalmology-NS
Pathology

Podiatry, No Surgery
Psychiatry
Rheumatology
Other, Specialty NOC

CLASS 3

Pediatrics-NMRP
Other, Specialty NOC

CLASS 4

Diabetes
Family Practice-NMRP, NS
General Practice-NMRP, NS
General Surgery-NMRP
Hematology
Industrial Medicine
Neurosurgery-NMRP, NMajS
Nuclear Medicine
Oncology
Ophthalmic Surgery
Oral/Maxillofacial Surgery
Orthopaedics-NMRP, NS
Radiation Oncology
Thoracic Surgery-NMRP, NS
Other, Specialty NOC

CLASS 5

Cardiovascular Disease-NMRP, NS
Infectious Disease
Nephrology-NMRP
Other, Specialty NOC

CLASS 6

Gynecology-NMRP, NS
Internal Medicine-NMRP
Certified Registered Nurse Anesthetist
Other, Specialty NOC

CLASS 7

Anesthesiology
Nephrology-MRP
Podiatry, Surgery
Pulmonary Diseases
Radiology-NMRP
Other, Specialty NOC

CLASS 8

Cardiac Surgery-MRP, NMajS
Cardiovascular Disease-Spec. MRP
Gastroenterology
General Surgery-MRP, NMajS
Hand Surgery-MRP, NMajS
Internal Medicine-MRP
Neurology
Orthopaedics-MRP, NMajS
Otorhinolaryngology-MRP, NMajS
Pediatrics-MRP
Radiology-MRP
Urology-MRP, NMajS
Vascular Surgery-MRP, NMajS
Other, Specialty NOC

CLASS 9

Family Practice-MRP, NMajS
General Practice-MRP, NMajS
Other, Specialty NOC

CLASS 10

Neurosurgery-MRP, NMajS
Urological Surgery
Other, Specialty NOC

CLASS 11

Cardiovascular Disease-MRP
Colon Surgery

Emergency Medicine-NMajS, prim
Gynecology/Obstetrics-MRP, Nmaj
Otorhinolaryngology; No Elective
Plastic
Radiology-MajRP
Other, Specialty NOC

CLASS 12

Emergency Medicine-MajS

Family Practice-not primarily MajS
General Practice-NMajS, prim
Gynecological Surgery
Hand Surgery
Head/Neck Surgery
Otorhinolaryngology; Head/Neck
Other, Specialty NOC

CLASS 13

General Surgery
Other, Specialty NOC

CLASS 14

Neonatology
Otorhinolaryngology; Other Than Head/Neck
Plastic Surgery
Other, Specialty NOC

CLASS 15

Orthopaedic Surgery s/o Spine
Other, Specialty NOC

CLASS 16

Cardiac Surgery
Thoracic Surgery
Vascular Surgery

Other, Specialty NOC

CLASS 17

Obstetrical/Gynecological Surgery
Other, Specialty NOC

CLASS 18

Neurosurgery-No Intracranial
Surgery
Orthopaedic Surgery wSpine
Other, Specialty NOC

CLASS 19

Neurosurgery
Other, Specialty NOC

MEDICAL PROCEDURE DEFINITIONS

NMRP: NOMINAL MINOR RISK PROCEDURE

NS: NO SURGERY

NOC: NOT OTHERWISE CLASSIFIED

NMAJS: NO MAJOR SURGERY

MRP: MINOR RISK PROCEDURES

MAJRP: MAJOR RISK PROCEDURES

NON PHYSICIAN HEALTH CARE PROVIDERS

Class X

Fellow, Intern, Optician, Resident, Social Worker

Class Y

Optometrist, Physical Therapist, X-Ray and Lab Technicians

Class Z

Nurse Practitioner – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Physician Assistant – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Psychologist – Class 1

Certified Registered Nurse Anesthetist
Shared Limits – 20% times Anesthesiologist rate
Separate Limits – 25% times Anesthesiologist rate

Certified Nurse Midwife – No complicated OB or surgery
Shared Limits – Not available
Separate Limits – 50% of OB/GYN rate

B. Territory Definitions

TERRITORY 1 COUNTIES

Cook, Jackson, Madison, St. Clair and Will

TERRITORY 2 COUNTIES

Lake, Vermillion

TERRITORY 3 COUNTIES

Kane, McHenry, Winnebago

TERRITORY 4 COUNTIES

DuPage, Kankakee, Macon

TERRITORY 5 COUNTIES

Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle, Randolph

TERRITORY 6 COUNTIES

Grundy, Sangamon

TERRITORY 7 COUNTIES

Peoria

TERRITORY 8 COUNTIES

Remainder of State

C. Standard Claims Made Program Step Factors

First Year:	25%
Second Year:	50%
Third Year:	78%
Fourth Year:	90%
Fifth Year (Mature):	100%

Mature Rates for Physicians and Surgeons (Claims-made):

$1,000,000 / 3,000,000

Class	Medical Specialty	Terr 1	Terr 2	Terr 3	Terr 4	Terr 5	Terr 6	Terr 7	Terr 8
1	Allergy/Immunology	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Forensic Medicine	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Occupational Medicine	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Otorhinolaryngology-NMRP, NS	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999

1	Physical Med. & Rehab.	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Public Health & Preventative Med	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Other, Specialty NOC	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
2	Dermatology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Endocrinology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Geriatrics	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Ophthalmology-NS	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Pathology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Podiatry, No Surgery	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Psychiatry	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Rheumatology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Other, Specialty NOC	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
3	Pediatrics-NMRP	22,579	20,473	19,422	17,316	16,261	14,155	10,998	12,049
3	Other, Specialty NOC	22,579	20,473	19,422	17,316	16,261	14,155	10,998	12,049
4	Diabetes	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Family Practice-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	General Practice-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	General Surgery-NMRP	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Hematology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Industrial Medicine	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Neurosurgery-NMRP, NMajS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Nuclear Medicine	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Oncology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Ophthalmic Surgery	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Oral/Maxillofacial Surgery	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Orthopaedics-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Radiation Oncology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Thoracic Surgery-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Other, Specialty NOC	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289

5	Cardiovascular Disease-NMRP, NS	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Infectious Disease	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Nephrology-NMRP	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Other, Specialty NOC	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
6	Gynecology-NMRP, NS	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
6	Internal Medicine-NMRP	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
6	Other, Specialty NOC	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
7	Anesthesiology	37,159	33,595	31,813	28,231	26,467	22,903	17,557	19,339
7	Nephrology-MRP	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Podiatry, Surgery	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Pulmonary Diseases	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Radiology-NMRP	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Other, Specialty NOC	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
8	Cardiac Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Cardiovascular Disease-Spec. MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Gastroenterology	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	General Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Hand Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Internal Medicine-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Neurology	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Orthopaedics-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Otorhinolaryngology-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Pediatrics-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Radiology-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Urology-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Vascular Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Other, Specialty NOC	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769

9	Family Practice-MRP, NMajS	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
9	General Practice-MRP, NMajS	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
9	Other, Specialty NOC	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
10	Neurosurgery-MRP, NMajS	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
10	Urological Surgery	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
10	Other, Specialty NOC	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
11	Cardiovascular Disease-MRP	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Colon Surgery	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Emergency Medicine-NMajS, prim	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Gynecology/Obstetrics-MRP, Nmaj	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Otorhinolaryngology; No Elective Plastic	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Radiology-MajRP	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Other, Specialty NOC	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
12	Emergency Medicine-MajS	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Family Practice-not primarily MajS	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	General Practice-NMajS, prim	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Gynecological Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Hand Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Head/Neck Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Otorhinolaryngology; Head/Neck	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Other, Specialty NOC	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
13	General Surgery	88,999	80,251	75,877	67,129	62,755	54,007	40,885	45,259
13	Other, Specialty NOC	88,999	80,251	75,877	67,129	62,755	54,007	40,885	45,259

14	Neonatology	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Otorhinolaryngology; Other Than Head/Neck	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Plastic Surgery	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Other, Specialty NOC	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
15	Orthopaedic Surgery s/o Spine	101,956	91,915	86,893	76,849	71,827	61,783	46,717	51,739
15	Other, Specialty NOC	101,956	91,915	86,893	76,849	71,827	61,783	46,717	51,739
16	Cardiac Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Thoracic Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Vascular Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Other, Specialty NOC	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
17	Obstetrical/Gynecological Surgery	124,636	112,324	106,168	93,856	87,703	75,391	56,923	63,079
17	Other, Specialty NOC	124,636	112,324	106,168	93,856	87,703	75,391	56,923	63,079
18	Neurosurgery-No Intracranial Surgery	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
18	Orthopaedic Surgery wSpine	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
18	Other, Specialty NOC	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
19	Neurosurgery	205,636	185,224	175,018	154,606	135,400	123,988	93,373	103,576
19	Other, Specialty NOC	205,636	185,224	175,018	154,606	135,400	123,988	93,373	103,576

D. Mature Rates for non Physician Health Care Providers

Class X equals 0% of the Class 1 Physician/Surgeon rate, for shared limits; 10% of Class 4 rate for separate limits.

Class Y equals 0% of the Class 1 Physician/Surgeon rate, for shared limits; 15% of the Class 4 rate for separate limits.

Class Z equals 10% of the Class 1 Physician/Surgeon rate for shared limits; 25% of Class 1 Physician/Surgeon rate for separate limits.

Note any non-Physician Health Care Providers in Classes X, Y, or Z with exposure in the Emergency Room will require the referenced factor times the Class 11 rate.

E. Liability Limits Factors:

Limits		
	Physicians	Surgeons
500/1.0	.719	.719
1M/3M	1.0	1.0
2M/4M	1.36	1.55
3M/5M	1.52	1.73

F. Extended Reporting Period Coverage Factors:

1. The following represents the tail factors to be applied to the annual expiring discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

Year	Factor
1st	3.30
2nd	3.15
3rd	2.40
4th	2.00

2. For First Year Claims Made step, the corresponding factor above is applied pro-rata. For Second Year and all years of maturity, the

corresponding factor above is applied to the last year's (365 days) annualized premium from the date of cancellation.

3. The Reporting Period is unlimited.

G. Shared Limits Modification:

Not available.

H. Policy Writing Minimum Premium:

Physicians & Surgeons - $500.

I. Policy Writing Minimum Premium:

Non-Physician Healthcare Providers - $500

J. Separate Limits for Non-Physician and Surgeon Healthcare Providers Modification:

Class X: 20% of Class 1
Class Y: 25% of Class 1
Class Z: 35% of Class 1

K. Premium Modifications

For individual physicians and surgeons:

1. Part Time Physicians & Surgeons – 30%
2. Physicians in Training – 1st Year Resident – 50%, Resident – 40%, Fellow – 30%
3. Locum Tenens – no premium, subject to prior underwriting approval.
4. New Physicians & Surgeons – 30% for the first two years of practice.
5. Physician Teaching Specialists – Non-surgical – 50%, Surgical – 40%
6. Physician's Leave of Absence – full suspension of insurance and premium for up to one year, subject to underwriting approval.

L. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit based on the following schedule:

1. If claim free for 3 years but less than 5 years, a 5% credit shall be applied at the policy inception date.

2. If claim free for 5 years but less than 8 years, a 10% credit shall be applied at the policy inception date.

3 If claim free for 8 years but less than 10 years, a 15% credit shall be applied at the policy inception date.

4. If claim free for 10 years or more, a credit of 20% shall be applied at the policy inception date.

A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

M. Schedule Rating (not to be used in conjunction with Loss Rating)

1. Historical Loss Experience +/- 25%	The frequency or severity of claims for the insured(s) is greater/less than the expected experience for an insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.
2. Cumulative Years of Patient Experience. +/- 10%	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.
3. Classification Anomalies. +/-_ 25%	Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures. +/- 10%	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.
6. Number /Type of Patient Exposures. +/- 10%	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.
7. Organizational Size / Structure. +/- 10%	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
g. Medical Standards, Quality & Claim Review. +/- 10%	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees mat meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.
9. Other Risk Management Practices and Procedures. +/- 10%	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & Credentialing. +/- 10%	The insured(s) exhibits greater/less than normal participation and support of such activities.
11. Record - Keeping Practices. +/- 10%	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.

Maximum Modification	+ / - 50%

N. Deductible Credits

See V.C in Section III-4.

O. Experience Rating

See V.D in Section III-7.

P. Slot Rating for groups, subject to Underwriting

See VI.A in Section III-8.

-END OF SECTION III-

SECTION IV

Medicus Secured Protection Program

1. OVERVIEW

Medicus Insurance Company (hereinafter "Company") offers individual physician or group premium modifications to physicians who fail to meet standard rating criteria for premium computation under Section III of Medicus Insurance Company's Manual in order to afford physicians every reasonable opportunity to remain insured with an admitted standard insurer. The Secured Protection Program is an amendment to the Medicus Insurance Company Manual currently approved in the state and is incorporated by reference in Section IV. The Medicus Secured Protection Program (SPP) may be offered to new and renewal policies falling into this category. Qualifying circumstances include but are not limited to:

DEA License Suspension
Professional Misconduct
Successful Completion of Chemical Dependency Program
Adverse Claims Experience (Severity and/or Frequency)
Proctorship
Medical Board Sanctions or Fines
Unusual Practice Characteristics
Physical or Mental Health Impairments
Bare Exposure Period
Cosmetic Procedures Outside Scope of Formal Training

The majority of renewal business falling into this category is a result of higher than expected frequency and severity of claims. Coverage is offered to physicians who fall outside the parameters of the standard Medicus program but do not warrant coverage in the non- standard market. Insureds who have unsuccessfully appealed an underwriting decision of non-renewal are also eligible for coverage under this program.

2. Applicant Referral Criteria:

A. Eligibility-New Business

In lieu of declining a physician or group, the outlined surcharges on pages 5 through 10 of the Medicus Insurance Company Manual Section IV part 8. Medicus Secured Protection Program Rating Formula may be applied for a physician or group that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

B. Eligibility-Renewal Business

In lieu of nonrenewing a physician or group, the following surcharges may be applied for:

1. A physician or group whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard; or

2. A physician or group for whom underwriting information (other than claim severity and/or claim frequency) has been developed that does not meet the minimum underwriting guidelines established by the Company's

Manual Section III.

Surcharges are subject to the point ranges set forth on the Points Evaluation Worksheet (see pg. 10), surcharges of 50% to 400% will be applied as a percentage of the premium. Case reserve amounts on pending claims are adjusted pursuant to underwriting guidelines.

The Company will grant individual consideration to New Solo Applicants (i.e. those not members of a group). A solo physician may not be appropriate for the SPP.

3. LENGTH OF INSURED'S REHABILITATION

Each Insured accepted in the SPP shall be surcharged up to a maximum of 3 years under the SPP, subject to meeting minimum requirements of rehabilitation.

4. RATING APPROACH

Premium is calculated by applying the rate per physician on the rate pages from the Medicus Manual under Section III, in accordance with each individual's medical classification, territory designation and standard claims made program step factors. This 'base rate' or un-discounted premium is then multiplied by the appropriate surcharge amount calculated on the Points Evaluation Worksheet (see pg. 10). No other surcharges will apply concurrently with a physician or group category surcharge. Surcharges range from +50% to +400%. If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the insured has been claims free under the current Medicus Insurance Company Manual Section III part VII (6.) Claim Free Credit Program.

5. UNDERWRITING

Key factors considered in physician evaluation for the Medicus Secured Protection Program (SPP) other than bare exposure is the probability and degree of rehabilitation. Underwriting will evaluate the nature of each claim to determine if it represents a pattern of poor judgment. Further, additional consideration is given to a physician affiliated with a group that can provide additional support, influence, and/or oversight. This is also due in part to the Medicus philosophy and requirement that physicians practicing together must be insured by a common carrier (all or nothing rule). If the group otherwise has good experience, Medicus strives to work with the group and the physician to reach a mutually beneficial agreement. The goals of the SPP are that:

1. A physician returns to or stays in the standard Medicus program at a surcharge,
2. After three years becomes eligible to qualify for coverage under the standard rating rules, and
3. An entire group does not become uninsurable under the standard program due to the loss experience of one or two physicians.

It is foreseeable that a physician or physician group must be non-renewed based on an underwriting assessment that a group would be unable to resolve persisting issues resulting in continued losses within the 3-year period.

A. Coverage Modifications

1. The only limits available to physicians in the program are $1 million/$3 million or state minimum requirement.

2. The applicable corporate limit of any physician in the SPP is a shared limit. No separate limit is available (See SPP01 Secured Protection Plan Endorsement).

3. Policies may contain specific procedure limitation exclusions and other exclusions, (See Medicus Form A013 (Exclusion of Procedure Endorsement)) such as consent to settle, which will require the written agreement by the applicant prior to policy issuance.

4. Physicians may be required to carry an indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) deductible at the discretion of the underwriter not to exceed a $5,000 per physician per claim deductible with a $15,000 deductible annual aggregate.

B. Consent to Settle

Physicians insured under the Medicus Secured Protection Program (SPP) are issued policies with endorsements restricting consent to settle. While insured in the SPP, consent to settle lies with the Company. A physician is expected to be rehabilitated and to return back to the standard program where he/she will regain the right to consent.

C. Impaired Physicians

An impaired physician is identified as one who is monitored by the physician's resident state's Physician Health Program, medical board or similar organization. Physicians may be required to go through a formal recovery program depending upon the degree/nature of the chemical dependency. Upon discharge from an approved program, the physician signs an agreement for regular monitoring, including random urinalyses. Medicus will not insure physicians who do not allow us to obtain information from their treatment facility. This program also assists physicians suffering from mental disorders.

D. Prior Acts

Physicians entering the Medicus Secured Protection Program (SPP) with at least 2 years of prior acts coverage from the standard Medicus program shall carry over prior acts coverage as per the Medicus Insurance Company Manual Section I part XIV Prior Acts Coverage. Physicians with less than 2 years of prior acts coverage with Medicus Insurance Company will receive careful consideration of physician or group details before offering prior acts coverage.

E. Imposed Deductibles

Deductibles may apply either to indemnity only or indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) not to exceed $5,000 per claim with a $15,000 deductible annual aggregate. An imposed deductible may be endorsed to address claims frequency. All deductibles require financial guarantees.

6. PHYSICIAN OR GROUP MANAGEMENT

It will be mandatory for all insureds in the Medicus Secured Protection Program (SPP) to successfully complete 10 hours of approved CME programs each year. SPP insureds are eligible for Physician or Group Management discounts offered under Medicus Insurance Company Manual Sections III part III (K) Premium Modifications.

Approved programs will include, but are not limited to, the following physician or group management and quality assurance topics:

- Specialty and Procedure Specific Programs
- I've experienced a Maloccurance
- The Best Deposition You Can Give
- EMR Vulnerabilities
- Online Offerings through MedRisk or other approved programs
- Use of medication flow sheet for patients taking multiple and or long term medication, use of system to assure physician review of all reports (lab and x-ray consultations, etc.)
- Having patient completed health history questionnaire and use of SOAP or similar charting systems in a consistent, organized chart format

7. INTERNAL LOGISTICS

All Medicus Secured Protection Program (SPP) insureds will be monitored through the Medicus Insurance Company Software (MIC4). These insureds will be distinguished by a unique identifier (SPP), and underwritten under the electronic version of the Frequency & Severity Claims Schedule (see page 8) and Point Evaluation Worksheet (see page SPP 10). Each program insured will be monitored on a quarterly basis. If deemed necessary by the underwriting manager, the physician may be required to have an onsite physician or group management review, continued drug testing, or extend proctorship at the expense of the physician.

8. MEDICUS SECURED PROTECTION PROGRAM RATING FORMULA

POINTS SCHEDULE A
Claims within the last 10 years from date of Report

A.	Frequency and Severity Claims Schedule	Points from Schedule
B.	No Claims reported in the past five full years	-100

Drug or Alcohol Impairment- Health

A.	Has experienced drug, alcohol, or mental illness problems more than 5 years ago	50
B.	Has experienced drug, alcohol, or mental illness problems with the past 5 years	75
C.	Currently in treatment for unresolved substance abuse	150
D.	Any relapse with in the past 5 years	150
E.	Physical or mental impairment that impacted physician's ability to practice medicine safely.	100

Government Agency Actions

A.	Medical license in any state has been revoked.	150
B.	Medical license in any state has been suspended.	100
C.	Medical license has been placed on probation with restrictions on the type of services he or she can provide	75
D.	Medical license has been placed on probation for more than 5 years	75
E.	Medical license has been placed on probation for 1 to 5 years	50
F.	Medical license is under investigation	40
G.	Public letter of reprimand, fine, citation, etc.	50
H.	Failure to report license investigation as required by affirmative duty language in policy.	50
I.	During the preceding 5 year, DEA license has been revoked suspended or issued with special terms or conditions, or license has been voluntarily surrendered or not renewed, other than normal nonrenewal license substantiated by physician.	100
J.	Has been convicted or indicted of a criminal act, or has been found to be in a violation of a civil statute, per event.	
	Medically Related	
	Within 5 years	100
	More than 5 years	50
K.	Medicare/Medicaid investigation	40
L.	Loss of Medicare/Medicaid Privileges	50
M.	Loss of any health insurance provider privileges	50

Note: Items A,B,C,D,E,F,G and H - only applies per event -i.e., highest point value.

Inappropriate Patient Contact

A.	Proven with a single patient.	75
B.	Proven with more than one patient.	150
C.	Alleged with one or more patients.	50

POINTS SCHEDULE A (cont.)

Medical Education

A.	Attended more that one medical school or a residency program due to actual or planned disciplinary action	50
B.	Residency complete at two or more facilities	50
C.	Started, but did not complete, a full residency program.	50
D.	Did not begin a residency.	50
E.	Has never received board certification	50

Medical Records

A.	Records alterations with material change and intent	150
B.	Records alterations not a material change to records just cleaning up	25
C.	Generally poor record keeping.	50

Informed Consent

A.	Incomplete consent obtained.	25
B.	Lack of Informed consent.	50

Privileges - Any State

(Hospital, Surgery Center, Etc.)

A.	Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event).	50
B.	Privileges have been suspended in the past 10 years (per event).	100
C.	Privileges have been revoked in the past 10 years (per event).	150
D.	Has been notified by facility of its intent to:	
	Restrict Privileges	30
	Suspend Privileges	50
	Revoke Privileges	100
	Note: Only applies per Occurrence -i.e. highest point value	
E.	No Privileges at any facility	100
F.	Currently undergoing peer review.	75
G.	Notice of peer review received	50

Procedures

A.	Is performing a medical procedure that is considered experimental but not directly dangerous	15
B.	Is performing a medical procedure that is in violation of policy exclusions	50
C.	Is performing a procedure(s) not usual and customary to his/her medical specialty.	50
D.	Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous.	150
E.	Is performing a procedure(s) outside his/her medical specialty.	100
F.	Is performing high physician or group procedures within his/her medical specialty	100

Patient Safety / Physician or group Management

A.	Mandatory patient safety/physician or group management previously recommended and Failure to comply with physician or group management requirements.	100

B.	Mandatory patient safety/physician or group management previously recommended and insured had initial compliance but no follow through.	75
	Gaps in Medical Practice	
A.	Gaps in medical practice of 6-months to 1-year duration.	50
B.	Gaps in medical practice of 1-2 years duration.	100
C.	Gaps in medical practice greater than 2 years.	150
	Payment History	
A.	Two or more late payments within the last three years.	100
B.	Two or more cancellations for non-payment of premium within the last three years.	150
	Other	
A.	Uncooperative in Claims Handling	150
B.	Patient Load:	
	For Surgeons, 61-99 patients per week	50
	For Surgeons, 100 or more patients per week	100
	For all others, 101-149 patients per week	50
	For all others, 150 or more patients per week	100
C.	Advertising: If insured advertises his/her services on TV, newspapers, billboards or radio	25
D.	Uses collection agency that can file suit without insured's written consent.	25
E.	Previous insurance history (bare, insolvent prior insurer or non-renewed).	100
F.	Claim experience of Associates, Partners or Corporation:	
	If one member with claim(s)	75
	If more than one member with claim(s)	100
	Favorable experience of group as a whole	-150
G.	For each claim or suit in which the physician breached the standard of care:	
	Mixed Reviews	50
	All Negative Reviews	100
	Admitted or Clear Liability	100
H.	For two or more claims, suits or incidents arising out of the same or similar procedures or treatments.	50
I.	Claim is too early in discovery period:	
	Surgical Class	-100
	Non-Surgical Class	-50
J.	For each claim or suit in which expert reviewers state the insured met the standard of care:	
	Surgical Class	-150
	Non-Surgical Class	-100
K.	High-physician or group surgical patient selection.	150
L.	Reinstatement of nonrenewal due to company election	150
M.	Loss Ratio in excess of 500%.	150
N.	Loss Ratio less than 100%.	-100
O.	Discrepancies between application answers/documents and verification	150

FREQUENCY AND SEVERITY CLAIMS SCHEDULE

Insured: _____ Policy#: _____ (If Applicable)

Effective Date: _____ Review Date: _____

Claims Without Indemnity		
ALAE		
From:	**To:**	**Claim Score**
$5,001	$25,000	1
$25,001	$50,000	2
$50,001	$100,000	3
$100,001	& up	4

Claims With Indemnity		
Indemnity + ALAE		
From:	**To:**	**Claim Score**
$1	$25,000	4
$25,001	$50,000	5
$50,001	$100,000	6
$100,001	$250,000	7
$250,001	$500,000	8
$500,001	$750,000	9
$750,001	$1,000,000	11
$1,000,001	& up	13

	Claimant Name	Report Date	Indemnity	ALAE	Total	Claim Score
Claim # 1		/ /	$	$		
Claim # 2		/ /	$	$		
Claim # 3		/ /	$	$		
Claim # 4		/ /	$	$		
Claim # 5		/ /	$	$		
Claim # 6		/ /	$	$		
Claim # 7		/ /	$	$		
Claim # 8		/ /	$	$		
Claim # 9		/ /	$	$		
Claim # 10		/ /	$	$		

Total: _____

Completed by: _____ Approved by: _____

Frequency and Severity Claims Schedule (Continued)

Total Claim Score	Low Frequency Specialties No. of Years w/MIC 0 - 2	3 - 5	6 - 8	9 & up
2	75	50	30	20
3	100	75	55	45
4	125	100	80	70
5	150	125	105	95
6	175	150	130	120
7	200	175	155	145
8	225	200	180	170
9	250	225	205	195
10	275	250	230	220
11	300	275	255	245
12	325	300	280	270
13	350	325	305	295
14	375	350	330	320
15	400	375	355	345

Total Claim Score	High Frequency Specialties ** No. of Years w/MIC 0 - 2	3 - 4	5 - 6	7 & up
3	75	50	30	20
4	100	75	55	45
5	125	100	80	70
6	150	125	105	95
7	175	150	130	120
8	200	175	155	145
9	225	200	180	170
10	250	225	205	195
11	275	250	230	220
12	300	275	255	245
13	325	300	280	270
14	350	325	305	295
15	375	350	330	320

(1) As of Review Date.
(2) Add 25 points for each Total Claim Score above 15.

** Emergency Medicine, General Surgery, Gynecology, Neurosurgery , Obstetrics & Gynecology, Orthopedic Surgery, Plastic Surgery, Thoracic Surgery and Urology

Points Evaluation Worksheet

Insured: _____ Policy#: _____

Effective Date: _____

(If Applicable) Review Date: _____

Criteria	**Points**
Claims Frequency	
Drug or Alcohol Impairment – Health	
Government Agency Actions	
Inappropriate Patient Contact	
Medical Education	
Informed Consent	
Privileges – Any State	
Procedures	
Physician or group Management	
Gaps in Coverage	
Other	
Total Points:	

Ranges & Surcharges

Point Range	Surcharge
0 – 100	0%
101-130	40%
131 – 160	45%
161 – 190	50%
191 – 210	55%
211 – 250	60%
251 – 280	70%
281 – 300	80%

Point Range	Surcharge
301 – 325	90%
326 – 350	100%
351 – 370	125%
371 – 390	150%
391 – 410	175%
411 – 430	200%
431 – 450	225%
451 – 470	250%

Point Range	Surcharge
471 – 490	275%
491 – 510	300%
511 – 530	325%
531 – 550	350%
551 – 570	375%
571 – 590	400%
591+	Nonrenew

Comments: _____

Completed by: _____ Approved by: _____

-END OF MANUAL-

MEDICUS™ INSURANCE COMPANY

MANUAL

SECTION I

GENERAL RULES

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS AND NON-PHYSICIAN HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

II. APPLICATION OF GENERAL RULES

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section, with reference thereto.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

III. POLICY TERM

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short term policy period.

IV. LOCATION OF PRACTICE

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. However, should an insured practice in more than one rating territory and/or state, the following rule shall apply. If 10% or less of an insured's practice is in a higher rated territory, we use the lower rated territory. If more than 10% of an insured's practice is in a higher rated territory, we use the higher rated territory.

V. PREMIUM COMPUTATION

A. Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.

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V. PREMIUM COMPUTATION (Continued)

B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

VI. FACTORS OR MULTIPLIERS

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

VII. WHOLE DOLLAR RULE

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

A. Any amount involving $.50 or over shall be rounded up to the next highest whole dollar amount; and

B. Any amount involving $.49 or less shall be rounded down to the next lowest whole dollar amount.

VIII. ADDITIONAL PREMIUM CHARGES

A. Prorate all changes requiring additional premium.

B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

IX. RETURN PREMIUM FOR MID-TERM CHANGES

A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.

B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.

C. Retain the Policy Minimum Premium.

~~C.~~

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X. POLICY CANCELLATIONS

A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:

1. A policy is canceled at the Company's request,

~~2.~~ the insured no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

2.

~~X. POLICY CANCELLATIONS (Continued)~~

B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.

C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

XI. POLICY MINIMUM PREMIUM

1. The applicable minimum premium is determined by the type of health care provider shown on the appropriate Rate Pages.

2. Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

XII. PREMIUM PAYMENT PLAN

The Company offers the insured to pay in full or the following premium payment options:

A. The monthly premium payment plan requires a minimum of 12.5% of the total premium to be paid on or before the inception/renewal date of the policy and the policyholder is billed 10 monthly installments of 8.33% and a final installment of 4.17%.

B. The quarterly payment plan requires a 25% down payment and three installments of 25%.

C. Our Automated Clearing House (ACH) option allows the insured to have 12 equal monthly installments.

~~The Company will offer the insured premium payment options, outlined in Section III-24.~~

XIII. COVERAGE

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverages will be rated under Standard Claims-Made Rates.

XIV. BASIC LIMITS OF LIABILITY

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Basic Limits of Liability shall be those shown as applicable to the respective insureds.

XV. LIMITS OF LIABILITY

Individual Limits of Liability will be modified by Increased Limits factors as applicable for the respective insureds and used to develop the applicable premium.

XVI. PRIOR ACTS COVERAGE

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). The retroactive date can be advanced only at the request or with the written acknowledgment of the insured, subject to underwriting.

XVII. EXTENDED REPORTING PERIOD COVERAGE

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.

~~B.~~ The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.

~~XVII. EXTENDED REPORTING PERIOD COVERAGE (Continued)~~

B.

C. The premium for the Extended Reporting Period Coverage shall be determined by applying~~g~~ the Extended Reporting Period Coverage rating factors shown in Section III-21, F.~~the Extended Reporting Period Coverage rating factors shown in Section III-10.~~

D. Premium is fully earned and must be paid in full within 30 days of the expiration of the policy.

E. The Reporting Period is unlimited.

F. The Insured has 30 days after the policy is terminated to purchase the extended reporting period. The Extended Reporting Endorsement must be offered regardless of the reason for the termination

XVIII. PREMIUM MODIFICATIONS

Schedule Rating

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Physicians and Surgeons	+/-50
Healthcare Providers	+/-50

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SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

1. Professional Corporations, Partnerships and Associations

B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:

1. Are comprised of 2 or more physicians;

2. Are organized as a legal entity;

3. Maintain common facilities (including multiple locations) and support personnel; and

4. Maintain medical/dental records of patients of the group as a historical record of patient care.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Claims-Made Coverage

$1,000,000 Per Claim
$3,000,000 Aggregate

III. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations, limited liability companies, or other entity may be written with a separate limit of liability and shall be computed in the following manner:

The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. In order for the entity to be eligible for coverage, the Company must insure all member physicians or at least 60% of the physician members must be insured by the Company, and the remaining physicians must be insured by another professional liability program acceptable to the company.

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III. PREMIUM COMPUTATION (Continued)

Number of Insureds	Percent
1	25%
2-5	12%
6-9	10%
10-19	9%
20-49	7%
50 or more	5%

B. Vicarious Liability Charge

For each member physician not individually insured by the Company, a premium charge will be made up to 30% of the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.

~~For each member physician not individually insured by the Company, a premium charge will be made up to 30% of the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.~~

IV. CLASSIFICATIONS

A. Corporations, Partnerships and Associations

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Not otherwise identified as a Miscellaneous Entity.

B. Miscellaneous Entities

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Including the following types of entities:

   a. Urgent Care Center

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b. Surgi Center
c. MRI Center
d. Renal Dialysis Center
e. Peritoneal Dialysis Center

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated under D1 on this page, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III-220.

B. Manual Rates

1. Corporations, Partnerships & Associations Rating Factors

As referenced in III in Section II-2:

See Table in Section II-2. Separate Corporate Limits

0% - Shared Corporate Limits

2. Miscellaneous Entities

Not eligible under this Filing.

C. Policy Writing Minimum Premium

The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of $500.

D. Premium Modifications

1. Schedule Rating—Partnerships & Corporations

Physician & Surgeons	+/- 50%

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Health Care Providers	+/-50%

2. Self-Insured Retention Credits - See Section III.V.B

- END OF SECTION II-

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SECTION III

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

I. APPLICATION OF MANUAL

This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Physicians/Surgeons and employed or associated non- physician health care providers.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

Claims-Made Coverage

$1,000,000 Per Claim

$3,000,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per physician, surgeon or non-physician health care provider shown in Section III-17 to Section III-20, in accordance with each individual's medical classification and class plan designation.

IV. CLASSIFICATIONS

A. Physicians/Surgeons and Non Physician Health Care Providers

1. Each medical practitioner is assigned a Rate Class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The Rate Classes are found in Section III-10 to Section III-15 of this Manual.

B. Part Time Physicians

1. A physician who is determined to be working 20 hours or less a week may be considered a part time practitioner and may be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner are identified in Section III of this Manual.

~~2.~~ A Part Time Practitioner may include any practitioner in classes 1 through 8 only, except for Anesthesia and Emergency Medicine as identified in the class plan. The hours reported to the company for rating purposes are subject to audit, at the Company's discretion.

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2.

~~B. Part Time Physicians (Continued)~~

~~plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.~~

3. The part time credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

C. Physicians in Training

1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:

   a. First Year Resident (or Intern) - 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.

   b. Resident - various lengths of time depending upon medical specialty; 3 years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.

   c. Fellow - Follows completion of residency and is a higher level of training.

2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.

   a. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. The applicable credit is stated presented in Section III-20.

3. The credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

D. Locum Tenens Physician

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.

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1.

~~D. Locum Tenens Physician (Continued)~~

2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.

3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

~~3.~~

E. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:

   a. Residency;

   b. Fellowship program in their medical specialty

   c. Fulfillment of a military obligation in remuneration for medical school tuition;

   d. Medical school or specialty training program.

2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.

3. A reduced rate will be applied in accordance with the credits shown presented in Section III-20. No other credits are to apply concurrent with this rule.

F. Physician Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the insured's private practice.

   a. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program. Refer to K.5 in Section III-20 to determine the applicable credit.

2. Coverage is available for the private practice of a physician teaching specialist. The coverage will not apply to any aspect of the insured's teaching activities.

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a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.

~~F. Physician Teaching Specialists (Continued)~~

b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

c. No other credits are to apply concurrent with this rule.

d. The applicable percentages are presented on presented in Section III-20.

~~d.~~

G. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.

2. This will apply retroactively to the first day of disability or leave of absence.

3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.

4. The credit to be applied to the applicable rate is presented in Section III-20.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in Section III-22, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic

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review. The modification shall be based on one or more of the specific considerations identified in Section III-22.

B. Risk Management

1% credit will apply for each Company approved CME hour of risk management completed, up to a maximum of 5% credit per year, or attendance at a Company approved seminar.

C. Deductible Credits

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer up to ($1M/$3M). Deductibles are subject to approval by the Company based on financial statements to be submitted by the insured and financial guarantees are required. The Company reserves the right to require acceptable securitization in the amount of the per claim and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

1. Individual Deductibles

Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:

~~Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:~~

INDEMNITY ONLY		INDEMNITY AND ALAE	
DEDUCTIBLE PER CLAIM		DEDUCTIBLE PER CLAIM	
$5,000	2.5%	$5,000	6.5%
$10,000	4.5%	$10,000	11.5%
$15,000	6.0%	$15,000	15.0%
$20,000	8.0%	$20,000	17.5%
$25,000	9.0%	$25,000	20.0%
$50,000	15.0%	$50,000	30.5%
$100,000	25.0%	$100,000	40.0%
$200,000	37.5%	$200,000	55.0%

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$250,000	42.0%	$250,000	58.0%

The following Individual Deductibles are available on a Per Claim/Aggregate Basis. Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:

~~C. Deductible Credits (Continued)~~

Indemnity Only Per Claim/Aggregate		Indemnity & ALAE Per Claim/Aggregate	
$5000/15,000	2.0%	$5000/15,000	5.5%
$10,000/30,000	4.0%	$10,000/30,000	10.5%
$25,000/75,000	8.5%	$25,000/75,000	19.0%
$50,000/150,000	14.0%	$50,000/150,000	29.5%
$100,000/300,000	24.0%	$100,000/300,000	43.0%
$200,000/600,000	36.0%	$200,000/600,000	53.5%
$250,000/750,000	40.0%	$250,000/750,000	56.5%

2. Group Deductibles

An optional deductible, which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year. When the organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below. Group deductible amounts apply to primary premium up to $1M/3M only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate	Number of Insureds				Maximum Credit
($000)	2-19	20-40	41-60	61-100	
5/15	.020	.018	.015	.012	$10,500
10/30	.038	.035	.030	.024	21,000
25/75	.084	.079	.070	.058	52,500
50/150	.145	.139	.127	.109	105,000
100/300	.234	.228	.216	.196	120,000
200/600	.348	.346	.338	.321	420,000
250/75 0	.385	.385	.381	.368	525,000

~~C. Deductible Credits (Continued)~~

The following Group Deductibles are available for Indemnity & ALAE.

Indemnity & ALAE Deductible Per Claim/Aggregate	Number of Insureds				Maximum Credit
($000)	2-19	20-40	41-60	61-100	
5/15	.029	.026	.021	.017	$12,750
10/30	.068	.063	.054	.043	25,500
25/75	.119	.112	.099	.082	63,750
50/150	.186	.179	.163	.140	127,500
100/300	.258	.252	.239	.216	255,000
200/600	.396	.394	.385	.366	510,000
250/75 0	.467	.467	.462	.446	637,500

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D. Experience Rating

This plan applies to physicians and surgeons medical professional liability risks contained in medical groups. As used in this plan, the term "risk" means the exposures of medical groups which have common management, a common and mutually agreed risk management program or a financial relationship among all members which encourages high levels of quality control and a reduction in liability claims.

On an optional basis, large risks with sufficiently credible loss experience may be loss-rated to develop an appropriate premium. To be eligible for loss rating, a group must have at least for the latest 10-year period and at least $100,000 in estimated annual premium.

The experience period will be the latest completed 10 years. If 10 years are not available, consideration will be given to at least 5 complete years.

Losses are developed to ultimate and trended to cost levels for the proposed policy year. Losses will be capped at $250,000 per loss.

The experience period does not include the 12-month period immediately prior to the effective date of the experience modification.

The experience rating modification is calculated using the following formula:

$$\text{Credibility} \times \frac{\text{Adjusted Actual Loss Ratio} - \text{Adjusted Expected Loss Ratio}}{\text{Adjusted Expected Loss Ratio}} = \text{Experience Mod.}$$

~~D. Experience Rating (Continued)~~

Since the experience rating plan is applied on an individual risk basis, the final impact of these changes varies by individual medical group based on risk size and loss experience by year. As a result, the anticipated overall rate impact due to the changes in the experience rating plan is indeterminable. However, the primary purpose of this plan and the revisions is to more accurately distribute the cost of insurance among eligible insureds.

E. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claim free. A schedule is provided in Section III-20.

F. Individual Risk Rating

A risk may be individually rated by submitting a filing to the Illinois Department of Insurance, in accordance with Section 155.18(b)(4) of the Illinois Insurance Code.

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The code allows us to modify classification rates to produce rates for individual risks. Modifications of classifications of risks may be based upon size, expense, management, individual experience, location or dispersion of exposure, and shall apply to all risks under the same or substantially the same circumstances or conditions. We must list the standards by which variations in hazards or expense provisions are measured, in order to determine that a specific risk is so different in hazard/expense that it warrants individual rating.

VI. MODIFIED PREMIUM COMPUTATION

A. Slot Rating

1. Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.

2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

~~3.~~ Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Underwriting Vice President.

3.

B. Requirements for Waiver of Premium for Extended Reporting Period Coverage.

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

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3. The Reporting Period is unlimited.

C. Blending Rates

A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.

D. Per Patient Visit Rating

1. Standard Claims Made coverage for group practices is available, at the Company's option, on a per patient visit basis rather than on an individual physician basis. Coverage is provided on a shared or individual physician limit basis.

2. The number of patient visits equivalent to a physician year is 2500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour.

3. The applicable medical specialty rate is divided by the equivalent patient visits resulting in the patient visit rate to be applied to the visits projected for the policy period. The product of the patient visit rate and the projected visits results in the indicated manual premium.

4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.

5. Premium modifications for new physician, part time, teaching, risk management or claim free credit cannot be used in conjunction with this rating rule.

VII. PREMIUM COMPUTATION DETAILS

A. Classifications

1. Applicable to Standard Claims-Made Programs.

2. The following classification plan shall be used to determine the appropriate rating class for each individual insured.

~~2.~~

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PHYSICIANS & SURGEONS

CLASS 1

Allergy/Immunology
Forensic Medicine
Occupational Medicine
Otorhinolaryngology-NMRP, NS
Physical Med. & Rehab.

Public Health & Preventative Med
Other, Specialty NOC

CLASS 2

Dermatology
Endocrinology
Geriatrics
Ophthalmology-NS
Pathology
Podiatry, No Surgery
Psychiatry
Rheumatology
Other, Specialty NOC

CLASS 3

Pediatrics-NMRP
Other, Specialty NOC

CLASS 4

Diabetes
Family Practice-NMRP, NS
General Practice-NMRP, NS
General Surgery-NMRP
Hematology
Industrial Medicine
Neurosurgery-NMRP, NMajS
Nuclear Medicine

Oncology
Ophthalmic Surgery
Oral/Maxillofacial Surgery
Orthopaedics-NMRP, NS
Radiation Oncology
Thoracic Surgery-NMRP, NS
Other, Specialty NOC

CLASS 5

Cardiovascular Disease-NMRP, NS
Infectious Disease
Nephrology-NMRP
Other, Specialty NOC

CLASS 6

Gynecology-NMRP, NS
Internal Medicine-NMRP
Certified Registered Nurse Anesthetist
Other, Specialty NOC

CLASS 7

Anesthesiology
Nephrology-MRP
Podiatry, Surgery
Pulmonary Diseases
Radiology-NMRP
Other, Specialty NOC

CLASS 8

Cardiac Surgery-MRP, NMajS
Cardiovascular Disease-Spec. MRP
Gastroenterology
General Surgery-MRP, NMajS
Hand Surgery-MRP, NMajS
Internal Medicine-MRP
Neurology
Orthopaedics-MRP, NMajS
Otorhinolaryngology-MRP, NMajS

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Pediatrics-MRP
Radiology-MRP
Urology-MRP, NMajS
Vascular Surgery-MRP, NMajS
Other, Specialty NOC

CLASS 9

Family Practice-MRP, NMajS
General Practice-MRP, NMajS
Other, Specialty NOC

CLASS 10

Neurosurgery-MRP, NMajS
Urological Surgery
Other, Specialty NOC

CLASS 11

Cardiovascular Disease-MRP
Colon Surgery

Emergency Medicine-NMajS, prim
Gynecology/Obstetrics-MRP,
Nmaj
Otorhinolaryngology; No Elective
Plastic
Radiology-MajRP
Other, Specialty NOC

CLASS 12

Emergency Medicine-MajS

Family Practice-not primarily MajS
General Practice-NMajS, prim
Gynecological Surgery
Hand Surgery
Head/Neck Surgery
Otorhinolaryngology; Head/Neck

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Other, Specialty NOC

CLASS 13

General Surgery
Other, Specialty NOC

CLASS 14

Neonatology
Otorhinolaryngology; Other Than Head/Neck
Plastic Surgery
Other, Specialty NOC

CLASS 15

Orthopaedic Surgery s/o Spine
Other, Specialty NOC

CLASS 16

Cardiac Surgery
Thoracic Surgery
Vascular Surgery
Other, Specialty NOC

CLASS 17

Obstetrical/Gynecological Surgery
Other, Specialty NOC

CLASS 18

Neurosurgery-No Intracranial Surgery
Orthopaedic Surgery wSpine
Other, Specialty NOC

CLASS 19

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Neurosurgery
Other, Specialty NOC

MEDICAL PROCEDURE DEFINITIONS

NMRP: NOMINAL MINOR RISK PROCEDURE

NS: NO SURGERY

NOC: NOT OTHERWISE CLASSIFIED

NMAJS: NO MAJOR SURGERY

MRP: MINOR RISK PROCEDURES

MAJRP: MAJOR RISK PROCEDURES

NON PHYSICIAN HEALTH CARE PROVIDERS

Class X

Fellow, Intern, Optician, Resident, Social Worker

Class Y

Optometrist, Physical Therapist, X-Ray and Lab Technicians

Class Z

Nurse Practitioner – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Physician Assistant – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Psychologist – Class 1

Certified Registered Nurse Anesthetist
Shared Limits – 20% times Anesthesiologist rate
Separate Limits – 25% times Anesthesiologist rate

Certified Nurse Midwife – No complicated OB or surgery
Shared Limits – Not available

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Separate Limits – 50% of OB/GYN rate

B. Territory Definitions

TERRITORY 1 COUNTIES

Cook, Jackson, Madison, St. Clair and Will

TERRITORY 2 COUNTIES

Lake, Vermillion

TERRITORY 3 COUNTIES

Kane, McHenry, Winnebago

TERRITORY 4 COUNTIES

DuPage, Kankakee, Macon

TERRITORY 5 COUNTIES

Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle, Randolph

TERRITORY 6 COUNTIES

Grundy, Sangamon

TERRITORY 7 COUNTIES

Peoria

TERRITORY 8 COUNTIES

Remainder of State

C. Standard Claims Made Program Step Factors

First Year:	25%
Second Year:	50%
Third Year:	78%
Fourth Year:	90%
Fifth Year (Mature):	100%

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Mature Rates for Physicians and Surgeons (Claims-made):

$1,000,000 / 3,000,000

Class	Medical Specialty	Terr 1	Terr 2	Terr 3	Terr 4	Terr 5	Terr 6	Terr 7	Terr 8
1	Allergy/Immunology	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Forensic Medicine	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Occupational Medicine	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Otorhinolaryngology-NMRP, NS	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Physical Med. & Rehab.	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Public Health & Preventative Med	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Other, Specialty NOC	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
2	Dermatology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Endocrinology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Geriatrics	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Ophthalmology-NS	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Pathology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Podiatry, No Surgery	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Psychiatry	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Rheumatology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Other, Specialty NOC	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
3	Pediatrics-NMRP	22,579	20,473	19,422	17,316	16,261	14,155	10,998	12,049

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3	Other, Specialty NOC	22,579	20,473	19,422	17,316	16,261	14,155	10,998	12,049
4	Diabetes	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Family Practice-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	General Practice-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	General Surgery-NMRP	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Hematology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Industrial Medicine	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Neurosurgery-NMRP, NMajS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Nuclear Medicine	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Oncology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Ophthalmic Surgery	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Oral/Maxillofacial Surgery	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Orthopaedics-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Radiation Oncology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Thoracic Surgery-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Other, Specialty NOC	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
5	Cardiovascular Disease-NMRP, NS	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Infectious Disease	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Nephrology-NMRP	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Other, Specialty NOC	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
6	Gynecology-NMRP, NS	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
6	Internal Medicine-NMRP	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
6	Other, Specialty NOC	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
7	Anesthesiology	37,159	33,595	31,813	28,231	26,467	22,903	17,557	19,339
7	Nephrology-MRP	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Podiatry, Surgery	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Pulmonary Diseases	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Radiology-NMRP	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339

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7	Other, Specialty NOC	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
8	Cardiac Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Cardiovascular Disease-Spec. MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Gastroenterology	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	General Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Hand Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Internal Medicine-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Neurology	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Orthopaedics-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Otorhinolaryngology-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Pediatrics-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Radiology-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Urology-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Vascular Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Other, Specialty NOC	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
9	Family Practice-MRP, NMajS	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
9	General Practice-MRP, NMajS	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
9	Other, Specialty NOC	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
10	Neurosurgery-MRP, NMajS	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
10	Urological Surgery	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
10	Other, Specialty NOC	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
11	Cardiovascular Disease-MRP	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Colon Surgery	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Emergency Medicine-NMajS, prim	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Gynecology/Obstetrics-MRP, Nmaj	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439

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	Otorhinolaryngology; No Elective								
11	Plastic	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Radiology-MajRP	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Other, Specialty NOC	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
	Emergency								
12	Medicine-MajS	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Family Practice-not primarily MajS	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	General Practice-NMajS, prim	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Gynecological Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Hand Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Head/Neck Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Otorhinolaryngology; Head/Neck	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Other, Specialty NOC	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
13	General Surgery	88,999	80,251	75,877	67,129	62,755	54,007	40,885	45,259
13	Other, Specialty NOC	88,999	80,251	75,877	67,129	62,755	54,007	40,885	45,259
14	Neonatology	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Otorhinolaryngology; Other Than Head/Neck	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Plastic Surgery	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Other, Specialty NOC	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
	Orthopaedic								
15	Surgery s/o Spine	101,956	91,915	86,893	76,849	71,827	61,783	46,717	51,739
15	Other, Specialty NOC	101,956	91,915	86,893	76,849	71,827	61,783	46,717	51,739
16	Cardiac Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Thoracic Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Vascular Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Other, Specialty NOC	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839

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17	Obstetrical/Gynecological Surgery	124,636	112,324	106,168	93,856	87,703	75,391	56,923	63,079
17	Other, Specialty NOC	124,636	112,324	106,168	93,856	87,703	75,391	56,923	63,079
18	Neurosurgery-No Intracranial Surgery	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
18	Orthopaedic Surgery wSpine	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
18	Other, Specialty NOC	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
19	Neurosurgery	205,636	185,224	175,018	154,606	135,400	123,988	93,373	103,576
19	Other, Specialty NOC	205,636	185,224	175,018	154,606	135,400	123,988	93,373	103,576

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D. Mature Rates for non Physician Health Care Providers

Class X equals 0% of the Class 1 Physician/Surgeon rate, for shared limits; 10% of Class 4 rate for separate limits.

Class Y equals 0% of the Class 1 Physician/Surgeon rate, for shared limits; 15% of the Class 4 rate for separate limits.

Class Z equals 10% of the Class 1 Physician/Surgeon rate for shared limits; 25% of Class 1 Physician/Surgeon rate for separate limits.

Note any non-Physician Health Care Providers in Classes X, Y, or Z with exposure in the Emergency Room will require the referenced factor times the Class 11 rate.

E. Liability Limits Factors:

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Limits		
	Physicians	Surgeons
500/1.0	.719	.719
1M/3M	1.0	1.0
2M/4M	1.36	1.55
3M/5M	1.52	1.73

F. Extended Reporting Period Coverage Factors:

1. The following represents the tail factors to be applied to the annual discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

Year	Factor
1st	3.30
2nd	3.15
3rd	2.40
4th	2.00

2. For First Year Claims Made step, the corresponding factor above is applied pro-rata. For Second Year and all years of maturity, the corresponding factor above is applied to the ~~expiring premium.~~ last year's (365 days) annualized premium from the date of cancellation.

~~F. Extended Reporting Period Coverage Factors (Continued):~~

3. The Reporting Period is unlimited.

G. Shared Limits Modification:

Not available.

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H. Policy Writing Minimum Premium:

Physicians & Surgeons - $500.

I. Policy Writing Minimum Premium:

Non-Physician Healthcare Providers - $500

J. Separate Limits for Non-Physician and Surgeon Healthcare Providers Modification:

Class X: 20% of Class 1
Class Y: 25% of Class 1
Class Z: 35% of Class 1

K. Premium Modifications

~~For individual physicians and surgeons:~~

~~1. Part Time Physicians & Surgeons – 30%~~
~~2. Physicians in Training – 1st Year Resident 50%; Resident 40%; Fellow 30%.~~
~~3. Locum Tenens – no premium, subject to prior underwriting approval~~
~~4. New Physicians & Surgeons – 30% for the first two years of practice~~
~~5. Physician Teaching Specialists – Non-surgical 50%; Surgical 40%.~~
~~6. Physician's Leave of Absence – full suspension of insurance and premium for up to one year, subject to underwriting approval~~

For individual physicians and surgeons:

1. Part Time Physicians & Surgeons – 30%
2. Physicians in Training – 1st Year Resident – 50%, Resident – 40%, Fellow – 30%
3. Locum Tenens – no premium, subject to prior underwriting approval.
4. New Physicians & Surgeons – 30% for the first two years of practice.
5. Physician Teaching Specialists – Non-surgical – 50%, Surgical – 40%
6. Physician's Leave of Absence – full suspension of insurance and premium for up to one year, subject to underwriting approval.

L. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit based on the following schedule:

1. If claim free for 3 years but less than 5 years, a 5% credit shall be applied at the policy inception date. ~~[indented over]~~

2. If claim free for 5 years but less than 8 years, a 10% credit shall be applied at the policy inception date.

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3 If claim free for 8 years but less than 10 years, a 15% credit shall be applied at the policy inception date.

4. If claim free for 10 years or more, a credit of 20% shall be applied at the policy inception date.

A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

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M. Schedule Rating (not to be used in conjunction with Loss Rating)

1. Historical Loss Experience +/- 25%	The frequency or severity of claims for the insured(s) is greater/less than the expected experience for an insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.
2. Cumulative Years of Patient Experience. +/- 10%	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.
3. Classification Anomalies. +/-_ 25%	Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures. +/- 10%	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.
6. Number /Type of Patient Exposures. +/- 10%	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.
7. Organizational Size / Structure. +/- 10%	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
g. Medical Standards, Quality & Claim Review. +/- 10%	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees mat meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.
9. Other Risk Management Practices and Procedures. +/- 10%	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & Credentialing. +/- 10%	The insured(s) exhibits greater/less than normal participation and support of such activities.
11. Record - Keeping Practices. +/- 10%	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.

Maximum Modification	+ / - 50%

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N. Deductible Credits

See V.C in Section III-4.

O. Experience Rating

See V.D in Section III-7.

P. Slot Rating for groups, subject to Underwriting

See VI.A in Section III-8.

~~Q. Mandatory Quarterly Payment Option.~~

~~For medical liability insureds whose annual premiums total $500 or more, the plan must allow the option of quarterly payments.~~

1. ~~An initial payment of no more than 40% of the estimated total premium due at policy inception;~~
2. ~~The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;~~
3. ~~No interest charges;~~
4. ~~Installment charges or fees of no more than the lesser of 1% of the total premium or $25, whichever is less; and~~
5. ~~A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.~~

~~Non-Mandatory Quarterly Payment Option.~~

1. ~~For medical liability insureds whose annual premiums are less than $500, insurers may, but are not required to, offer quarterly installment , premium payment plans.~~
2. ~~For insureds who pay a premium for any extension of a reporting period, insurers may, but are not required to, offer quarterly installment, premium payment plans.~~
3. ~~If an insurer offers any quarterly payments under this sub-section, (g) Non-Mandatory Quarterly Payment Options, they must be offered to all medical liability insureds.~~

~~Quarterly installment premium payment plans subject to (R) above shall be included in the initial offer of the policy, or in the first policy renewal. Thereafter, the insurer may, but need not, re-offer the payment plan, but if an insured requests the payment plan at a later date, the insurer must make it available.~~

-END OF SECTION III-

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SECTION IV

Medicus Secured Protection Program

1. OVERVIEW

Medicus Insurance Company (hereinafter "Company") offers individual physician or group premium modifications to physicians who fail to meet standard rating criteria for premium computation under Section III of Medicus Insurance Company's Manual in order to afford physicians every reasonable opportunity to remain insured with an admitted standard insurer. The Secured Protection Program is an amendment to the Medicus Insurance Company Manual currently approved in the state and is incorporated by reference in Section IV. The Medicus Secured Protection Program (SPP) may be offered to new and renewal policies falling into this category. Qualifying circumstances include but are not limited to:

DEA License Suspension
Professional Misconduct
Successful Completion of Chemical Dependency Program
Adverse Claims Experience (Severity and/or Frequency)
Proctorship
Medical Board Sanctions or Fines
Unusual Practice Characteristics
Physical or Mental Health Impairments
Bare Exposure Period
Cosmetic Procedures Outside Scope of Formal Training

The majority of renewal business falling into this category is a result of higher than expected frequency and severity of claims. Coverage is offered to physicians who fall outside the parameters of the standard Medicus program but do not warrant coverage in the non- standard market. Insureds who have unsuccessfully appealed an underwriting decision of non-renewal are also eligible for coverage under this program.

2. Applicant Referral Criteria:

A. Eligibility-New Business

In lieu of declining a physician or group, the outlined surcharges on pages 5 through 10 of the Medicus Insurance Company Manual Section IV part 8. Medicus Secured Protection Program Rating Formula may be applied for a physician or group that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

B. Eligibility-Renewal Business

In lieu of nonrenewing a physician or group, the following surcharges may be applied for:

1. A physician or group whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard; or

2. A physician or group for whom underwriting information (other than claim severity and/or claim frequency) has been developed that does not meet the minimum underwriting guidelines established by the Company's

Manual Section III.

Surcharges are subject to the point ranges set forth on the Points Evaluation Worksheet (see pg. 10), surcharges of 50% to 400% will be applied as a percentage of the premium. Case reserve amounts on pending claims are adjusted pursuant to underwriting guidelines.

The Company will grant individual consideration to New Solo Applicants (i.e. those not members of a group). A solo physician may not be appropriate for the SPP.

3. LENGTH OF INSURED'S REHABILITATION

Each Insured accepted in the SPP shall be surcharged up to a maximum of 3 years under the SPP, subject to meeting minimum requirements of rehabilitation.

4. RATING APPROACH

Premium is calculated by applying the rate per physician on the rate pages from the Medicus Manual under Section III, in accordance with each individual's medical classification, territory designation and standard claims made program step factors. This 'base rate' or un-discounted premium is then multiplied by the appropriate surcharge amount calculated on the Points Evaluation Worksheet (see pg. 10). No other surcharges will apply concurrently with a physician or group category surcharge. Surcharges range from +50% to +400%. If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the insured has been claims free under the current Medicus Insurance Company Manual Section III part VII (6.) Claim Free Credit Program.

5. UNDERWRITING

Key factors considered in physician evaluation for the Medicus Secured Protection Program (SPP) other than bare exposure is the probability and degree of rehabilitation. Underwriting will evaluate the nature of each claim to determine if it represents a pattern of poor judgment. Further, additional consideration is given to a physician affiliated with a group that can provide additional support, influence, and/or oversight. This is also due in part to the Medicus philosophy and requirement that physicians practicing together must be insured by a common carrier (all or nothing rule). If the group otherwise has good experience, Medicus strives to work with the group and the physician to reach a mutually beneficial agreement. The goals of the SPP are that:

1. A physician returns to or stays in the standard Medicus program at a surcharge,
2. After three years becomes eligible to qualify for coverage under the standard rating rules, and
3. An entire group does not become uninsurable under the standard program due to the loss experience of one or two physicians.

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It is foreseeable that a physician or physician group must be non-renewed based on an underwriting assessment that a group would be unable to resolve persisting issues resulting in continued losses within the 3-year period.

A. Coverage Modifications

1. The only limits available to physicians in the program are $1 million/$3 million or state minimum requirement.

2. The applicable corporate limit of any physician in the SPP is a shared limit. No separate limit is available (See SPP01 Secured Protection Plan Endorsement).

3. Policies may contain specific procedure limitation exclusions and other exclusions, (See Medicus Form A013 (Exclusion of Procedure Endorsement)) such as consent to settle, which will require the written agreement by the applicant prior to policy issuance.

4. Physicians may be required to carry an indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) deductible at the discretion of the underwriter not to exceed a $5,000 per physician per claim deductible with a $15,000 deductible annual aggregate.

B. Consent to Settle

Physicians insured under the Medicus Secured Protection Program (SPP) are issued policies with endorsements restricting consent to settle. While insured in the SPP, consent to settle lies with the Company. A physician is expected to be rehabilitated and to return back to the standard program where he/she will regain the right to consent.

C. Impaired Physicians

An impaired physician is identified as one who is monitored by the physician's resident state's Physician Health Program, medical board or similar organization. Physicians may be required to go through a formal recovery program depending upon the degree/nature of the chemical dependency. Upon discharge from an approved program, the physician signs an agreement for regular monitoring, including random urinalyses. Medicus will not insure physicians who do not allow us to obtain information from their treatment facility. This program also assists physicians suffering from mental disorders.

D. Prior Acts

Physicians entering the Medicus Secured Protection Program (SPP) with at least 2 years of prior acts coverage from the standard Medicus program shall carry over prior acts coverage as per the Medicus Insurance Company Manual Section I part XIV Prior Acts Coverage. Physicians with less than 2 years of

prior acts coverage with Medicus Insurance Company will receive careful consideration of physician or group details before offering prior acts coverage.

E. Imposed Deductibles

Deductibles may apply either to indemnity only or indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) not to exceed $5,000 per claim with a $15,000 deductible annual aggregate. An imposed deductible may be endorsed to address claims frequency. All deductibles require financial guarantees.

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6. PHYSICIAN OR GROUP MANAGEMENT

It will be mandatory for all insureds in the Medicus Secured Protection Program (SPP) to successfully complete 10 hours of approved CME programs each year. SPP insureds are eligible for Physician or Group Management discounts offered under Medicus Insurance Company Manual Sections III part III (K) Premium Modifications.

Approved programs will include, but are not limited to, the following physician or group management and quality assurance topics:

- Specialty and Procedure Specific Programs
- I've experienced a Maloccurance
- The Best Deposition You Can Give
- EMR Vulnerabilities
- Online Offerings through MedRisk or other approved programs
- Use of medication flow sheet for patients taking multiple and or long term medication, use of system to assure physician review of all reports (lab and x-ray consultations, etc.)
- Having patient completed health history questionnaire and use of SOAP or similar charting systems in a consistent, organized chart format

7. INTERNAL LOGISTICS

All Medicus Secured Protection Program (SPP) insureds will be monitored through the Medicus Insurance Company Software (MIC4). These insureds will be distinguished by a unique identifier (SPP), and underwritten under the electronic version of the Frequency & Severity Claims Schedule (see page 8) and Point Evaluation Worksheet (see page SPP 10). Each program insured will be monitored on a quarterly basis. If deemed necessary by the underwriting manager, the physician may be required to have an onsite physician or group management review, continued drug testing, or extend proctorship at the expense of the physician.

8. MEDICUS SECURED PROTECTION PROGRAM RATING FORMULA

POINTS SCHEDULE A
Claims within the last 10 years from date of Report

A.	Frequency and Severity Claims Schedule	Points from Schedule
B.	No Claims reported in the past five full years	-100

Drug or Alcohol Impairment- Health

A.	Has experienced drug, alcohol, or mental illness problems more than 5 years ago	50
B.	Has experienced drug, alcohol, or mental illness problems with the past 5 years	75
C.	Currently in treatment for unresolved substance abuse	150
D.	Any relapse with in the past 5 years	150
E.	Physical or mental impairment that impacted physician's ability to practice medicine safely.	100

Government Agency Actions

A.	Medical license in any state has been revoked.	150
B.	Medical license in any state has been suspended.	100
C.	Medical license has been placed on probation with restrictions on the type of services he or she can provide	75
D.	Medical license has been placed on probation for more than 5 years	75
E.	Medical license has been placed on probation for 1 to 5 years	50
F.	Medical license is under investigation	40
G.	Public letter of reprimand, fine, citation, etc.	50
H.	Failure to report license investigation as required by affirmative duty language in policy.	50
I.	During the preceding 5 year, DEA license has been revoked suspended or issued with special terms or conditions, or license has been voluntarily surrendered or not renewed, other than normal nonrenewal license substantiated by physician.	100
J.	Has been convicted or indicted of a criminal act, or has been found to be in a violation of a civil statute, per event.	
	Medically Related	
	Within 5 years	100
	More than 5 years	50
K.	Medicare/Medicaid investigation	40
L.	Loss of Medicare/Medicaid Privileges	50
M.	Loss of any health insurance provider privileges	50

Note: Items A,B,C,D,E,F,G and H - only applies per event -i.e., highest point value.

Inappropriate Patient Contact

A.	Proven with a single patient.	75
B.	Proven with more than one patient.	150
C.	Alleged with one or more patients.	50

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POINTS SCHEDULE A (cont.)

Medical Education

A.	Attended more that one medical school or a residency program due to actual or planned disciplinary action	50
B.	Residency complete at two or more facilities	50
C.	Started, but did not complete, a full residency program.	50
D.	Did not begin a residency.	50
E.	Has never received board certification	50

Medical Records

A.	Records alterations with material change and intent	150
B.	Records alterations not a material change to records just cleaning up	25
C.	Generally poor record keeping.	50

Informed Consent

A.	Incomplete consent obtained.	25
B.	Lack of Informed consent.	50

Privileges - Any State

(Hospital, Surgery Center, Etc.)

A.	Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event).	50
B.	Privileges have been suspended in the past 10 years (per event).	100
C.	Privileges have been revoked in the past 10 years (per event).	150
~~E~~D.	Has been notified by facility of its intent to:	
	Restrict Privileges	30
	Suspend Privileges	50
	Revoke Privileges	100
	Note: Only applies per Occurrence -i.e. highest point value	
~~F~~E.	No Privileges at any facility	100
~~G~~F.	Currently undergoing peer review.	75
~~H~~G.	Notice of peer review received	50

Procedures

A.	Is performing a medical procedure that is considered experimental but not directly dangerous	15
B.	Is performing a medical procedure that is in violation of policy exclusions	50
C.	Is performing a procedure(s) not usual and customary to his/her medical specialty.	50
D.	Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous.	150
E.	Is performing a procedure(s) outside his/her medical specialty.	100
F.	Is performing high physician or group procedures within his/her medical specialty	100

Patient Safety / Physician or group Management

A.	Mandatory patient safety/physician or group management previously recommended and Failure to comply with physician or group management requirements.	100

B.	Mandatory patient safety/physician or group management previously recommended and insured had initial compliance but no follow through.	75
	Gaps in Medical Practice	
A.	Gaps in medical practice of 6-months to 1-year duration.	50
B.	Gaps in medical practice of 1-2 years duration.	100
C.	Gaps in medical practice greater than 2 years.	150
	Payment History	
A.	Two or more late payments within the last three years.	100
B.	Two or more cancellations for non-payment of premium within the last three years.	150
	Other	
A.	Uncooperative in Claims Handling	150
B.	Patient Load:	
	For Surgeons, 61-99 patients per week	50
	For Surgeons, 100 or more patients per week	100
	For all others, 101-149 patients per week	50
	For all others, 150 or more patients per week	100
C.	Advertising: If insured advertises his/her services on TV, newspapers, billboards or radio	25
D.	Uses collection agency that can file suit without insured's written consent.	25
E.	Previous insurance history (bare, insolvent prior insurer or non-renewed).	100
F.	Claim experience of Associates, Partners or Corporation:	
	If one member with claim(s)	75
	If more than one member with claim(s)	100
	Favorable experience of group as a whole	-150
G.	For each claim or suit in which the physician breached the standard of care:	
	Mixed Reviews	50
	All Negative Reviews	100
	Admitted or Clear Liability	100
H.	For two or more claims, suits or incidents arising out of the same or similar procedures or treatments.	50
I.	Claim is too early in discovery period:	
	Surgical Class	-100
	Non-Surgical Class	-50
J.	For each claim or suit in which expert reviewers state the insured met the standard of care:	
	Surgical Class	-150
	Non-Surgical Class	-100
K.	High-physician or group surgical patient selection.	150
L.	Reinstatement of nonrenewal due to company election	150
M.	Loss Ratio in excess of 500%.	150
N.	Loss Ratio less than 100%.	-100
O.	Discrepancies between application answers/documents and verification	150

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FREQUENCY AND SEVERITY CLAIMS SCHEDULE

Insured: _____ Policy#: _____

(If Applicable)

Effective Date: _____ Review Date: _____

Claims Without Indemnity		
ALAE		
From:	To:	Claim Score
$5,001	$25,000	1
$25,001	$50,000	2
$50,001	$100,000	3
$100,001	& up	4

Claims With Indemnity		
Indemnity + ALAE		
From:	To:	Claim Score
$1	$25,000	4
$25,001	$50,000	5
$50,001	$100,000	6
$100,001	$250,000	7
$250,001	$500,000	8
$500,001	$750,000	9
$750,001	$1,000,000	11
$1,000,001	& up	13

	Claimant Name	Report Date	Indemnity	ALAE	Total	Claim Score
Claim # 1		/ /	$	$		
Claim # 2		/ /	$	$		
Claim # 3		/ /	$	$		
Claim # 4		/ /	$	$		
Claim # 5		/ /	$	$		
Claim # 6		/ /	$	$		
Claim # 7		/ /	$	$		
Claim # 8		/ /	$	$		
Claim # 9		/ /	$	$		
Claim # 10		/ /	$	$		

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Total: _____

Completed by:_____ Approved by:_____

Frequency and Severity Claims Schedule (Continued)

Total Claim Score	Low Frequency Specialties No. of Years w/MIC 0 - 2	3 - 5	6 - 8	9 & up
2	75	50	30	20
3	100	75	55	45
4	125	100	80	70
5	150	125	105	95
6	175	150	130	120
7	200	175	155	145
8	225	200	180	170
9	250	225	205	195
10	275	250	230	220
11	300	275	255	245
12	325	300	280	270
13	350	325	305	295
14	375	350	330	320
15	400	375	355	345

Total Claim Score	High Frequency Specialties ** No. of Years w/MIC 0 - 2	3 - 4	5 - 6	7 & up
3	75	50	30	20
4	100	75	55	45
5	125	100	80	70
6	150	125	105	95
7	175	150	130	120
8	200	175	155	145
9	225	200	180	170
10	250	225	205	195
11	275	250	230	220
12	300	275	255	245
13	325	300	280	270
14	350	325	305	295
15	375	350	330	320

(1) As of Review Date.
(2) Add 25 points for each Total Claim Score above 15.

** Emergency Medicine, General Surgery, Gynecology, Neurosurgery , Obstetrics & Gynecology, Orthopedic Surgery, Plastic Surgery, Thoracic Surgery and Urology

Points Evaluation Worksheet

Insured: _____ Policy#: _____

Effective Date: _____ (If Applicable) Review Date: _____

Criteria	Points
Claims	
Frequency	
Drug or Alcohol Impairment – Health	
Government Agency Actions	
Inappropriate Patient Contact	
Medical Education	
Informed Consent	
Privileges – Any State	
Procedures	
Physician or group Management	
Gaps in Coverage	
Other	
Total Points:	

Ranges & Surcharges

Point Range	Surcharge
0 – 100	0%
101-130	40%
131 – 160	45%
161 – 190	50%
191 – 210	55%
211 – 250	60%
251 – 280	70%
281 – 300	80%

Point Range	Surcharge
301 – 325	90%
326 – 350	100%
351 – 370	125%
371 – 390	150%
391 – 410	175%
411 – 430	200%
431 – 450	225%
451 – 470	250%

Point Range	Surcharge
471 – 490	275%
491 – 510	300%
511 – 530	325%
531 – 550	350%
551 – 570	375%
571 – 590	400%
591+	Nonrenew

Comments: _____

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SERFF Tracking Number:	*MEIC-127346142*	*State:*	*Illinois*
Filing Company:	*Medicus Insurance Company*	*State Tracking Number:*	*MEIC-127346142*
Company Tracking Number:	*MIC MANUAL - 07/2011 RULE*		
TOI:	*11.2 Med Mal-Claims Made Only*	*Sub-TOI:*	*11.2000 Med Mal Sub-TOI Combinations*
Product Name:	*MIC Rate Manual - 07/2011*		
Project Name/Number:	*IL Rate Manual 07/2011/IL RM 07/2011*		

Supporting Document Schedules

Item Status: **Status Date:**

Bypassed - Item: Explanatory Memorandum
Bypass Reason: Please see the Filing Description under the General Information tab.
Comments:

Item Status: **Status Date:**

Bypassed - Item: Form RF3 - (Summary Sheet)
Bypass Reason: N/A - No rate change
Comments:

Item Status: **Status Date:**

Bypassed - Item: Certification
Bypass Reason: N/A - no rate change.
Comments:

Item Status: **Status Date:**

Satisfied - Item: Manual
Comments:
Please see the updated changes. No other changes have been made except for what is highlighted in this filing.
Attachment:
IL Rate Manual 07-2011_Changes Tracked.pdf

MEDICUS™ INSURANCE COMPANY

MANUAL

SECTION I

GENERAL RULES

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS AND NON-PHYSICIAN HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

II. APPLICATION OF GENERAL RULES

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section, with reference thereto.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

III. POLICY TERM

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short term policy period.

IV. LOCATION OF PRACTICE

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. However, should an insured practice in more than one rating territory and/or state, the following rule shall apply. If 10% or less of an insured's practice is in a higher rated territory, we use the lower rated territory. If more than 10% of an insured's practice is in a higher rated territory, we use the higher rated territory.

V. PREMIUM COMPUTATION

A. Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.

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V. PREMIUM COMPUTATION (Continued)

B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

VI. FACTORS OR MULTIPLIERS

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

VII. WHOLE DOLLAR RULE

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

A. Any amount involving $.50 or over shall be rounded up to the next highest whole dollar amount; and

B. Any amount involving $.49 or less shall be rounded down to the next lowest whole dollar amount.

VIII. ADDITIONAL PREMIUM CHARGES

A. Prorate all changes requiring additional premium.

B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

IX. RETURN PREMIUM FOR MID-TERM CHANGES

A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.

B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.

C. Retain the Policy Minimum Premium.

~~C.~~

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X. POLICY CANCELLATIONS

A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:

1. A policy is canceled at the Company's request,

~~2.~~ the insured no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

2.

~~X. POLICY CANCELLATIONS (Continued)~~

B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.

C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

XI. POLICY MINIMUM PREMIUM

1. The applicable minimum premium is determined by the type of health care provider shown on the appropriate Rate Pages.

2. Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

XII. PREMIUM PAYMENT PLAN

The Company offers the insured to pay in full or the following premium payment options:

A. The monthly premium payment plan requires a minimum of 12.5% of the total premium to be paid on or before the inception/renewal date of the policy and the policyholder is billed 10 monthly installments of 8.33% and a final installment of 4.17%.

B. The quarterly payment plan requires a 25% down payment and three installments of 25%.

C. Our Automated Clearing House (ACH) option allows the insured to have 12 equal monthly installments.

~~The Company will offer the insured premium payment options, outlined in Section III-24.~~

XIII. COVERAGE

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverages will be rated under Standard Claims-Made Rates.

XIV. BASIC LIMITS OF LIABILITY

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Basic Limits of Liability shall be those shown as applicable to the respective insureds.

XV. LIMITS OF LIABILITY

Individual Limits of Liability will be modified by Increased Limits factors as applicable for the respective insureds and used to develop the applicable premium.

XVI. PRIOR ACTS COVERAGE

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). The retroactive date can be advanced only at the request or with the written acknowledgment of the insured, subject to underwriting.

XVII. EXTENDED REPORTING PERIOD COVERAGE

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.

~~B.~~ The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.

~~XVII. EXTENDED REPORTING PERIOD COVERAGE (Continued)~~

B.

C. The premium for the Extended Reporting Period Coverage shall be determined by applying~~g~~ the Extended Reporting Period Coverage rating factors shown in Section III-21, F.~~the Extended Reporting Period Coverage rating factors shown in Section III-10.~~

D. Premium is fully earned and must be paid in full within 30 days of the expiration of the policy.

E. The Reporting Period is unlimited.

F. The Insured has 30 days after the policy is terminated to purchase the extended reporting period. The Extended Reporting Endorsement must be offered regardless of the reason for the termination

XVIII. PREMIUM MODIFICATIONS

Schedule Rating

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Physicians and Surgeons	+/-50
Healthcare Providers	+/-50

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SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

1. Professional Corporations, Partnerships and Associations

B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:

1. Are comprised of 2 or more physicians;

2. Are organized as a legal entity;

3. Maintain common facilities (including multiple locations) and support personnel; and

4. Maintain medical/dental records of patients of the group as a historical record of patient care.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Claims-Made Coverage

$1,000,000 Per Claim
$3,000,000 Aggregate

III. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations, limited liability companies, or other entity may be written with a separate limit of liability and shall be computed in the following manner:

The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. In order for the entity to be eligible for coverage, the Company must insure all member physicians or at least 60% of the physician members must be insured by the Company, and the remaining physicians must be insured by another professional liability program acceptable to the company.

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III. PREMIUM COMPUTATION (Continued)

Number of Insureds	Percent
1	25%
2-5	12%
6-9	10%
10-19	9%
20-49	7%
50 or more	5%

B. Vicarious Liability Charge

For each member physician not individually insured by the Company, a premium charge will be made up to 30% of the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.

~~For each member physician not individually insured by the Company, a premium charge will be made up to 30% of the appropriate specialty rate if the Company agrees to provide such vicarious liability coverage.~~

IV. CLASSIFICATIONS

A. Corporations, Partnerships and Associations

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Not otherwise identified as a Miscellaneous Entity.

B. Miscellaneous Entities

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Including the following types of entities:

   a. Urgent Care Center

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b. Surgi Center
c. MRI Center
d. Renal Dialysis Center
e. Peritoneal Dialysis Center

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated under D1 on this page, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified in Section III-220.

B. Manual Rates

1. Corporations, Partnerships & Associations Rating Factors

As referenced in III in Section II-2:

See Table in Section II-2. Separate Corporate Limits

0% - Shared Corporate Limits

2. Miscellaneous Entities

Not eligible under this Filing.

C. Policy Writing Minimum Premium

The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of $500.

D. Premium Modifications

1. Schedule Rating—Partnerships & Corporations

Physician & Surgeons	+/- 50%

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Health Care Providers	+/-50%

2. Self-Insured Retention Credits - See Section III.V.B

- END OF SECTION II-

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SECTION III

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

I. APPLICATION OF MANUAL

This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Physicians/Surgeons and employed or associated non- physician health care providers.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

Claims-Made Coverage

$1,000,000 Per Claim

$3,000,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per physician, surgeon or non-physician health care provider shown in Section III-17 to Section III-20, in accordance with each individual's medical classification and class plan designation.

IV. CLASSIFICATIONS

A. Physicians/Surgeons and Non Physician Health Care Providers

1. Each medical practitioner is assigned a Rate Class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The Rate Classes are found in Section III-10 to Section III-15 of this Manual.

B. Part Time Physicians

1. A physician who is determined to be working 20 hours or less a week may be considered a part time practitioner and may be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner are identified in Section III of this Manual.

~~2.~~ A Part Time Practitioner may include any practitioner in classes 1 through 8 only, except for Anesthesia and Emergency Medicine as identified in the class plan. The hours reported to the company for rating purposes are subject to audit, at the Company's discretion.

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2.

~~B. Part Time Physicians (Continued)~~

~~plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.~~

3. The part time credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

C. Physicians in Training

1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:

   a. First Year Resident (or Intern) - 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.

   b. Resident - various lengths of time depending upon medical specialty; 3 years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.

   c. Fellow - Follows completion of residency and is a higher level of training.

2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.

   a. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. The applicable credit is stated presented in Section III-20.

3. The credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

D. Locum Tenens Physician

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.

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1.

~~D. Locum Tenens Physician (Continued)~~

2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.

3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

~~3.~~

E. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:

   a. Residency;

   b. Fellowship program in their medical specialty

   c. Fulfillment of a military obligation in remuneration for medical school tuition;

   d. Medical school or specialty training program.

2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.

3. A reduced rate will be applied in accordance with the credits shown presented in Section III-20. No other credits are to apply concurrent with this rule.

F. Physician Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the insured's private practice.

   a. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program. Refer to K.5 in Section III-20 to determine the applicable credit.

2. Coverage is available for the private practice of a physician teaching specialist. The coverage will not apply to any aspect of the insured's teaching activities.

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a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.

~~F. Physician Teaching Specialists (Continued)~~

b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

c. No other credits are to apply concurrent with this rule.

d. The applicable percentages are presented on presented in Section III-20.

~~d.~~

G. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.

2. This will apply retroactively to the first day of disability or leave of absence.

3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.

4. The credit to be applied to the applicable rate is presented in Section III-20.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated in Section III-22, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic

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review. The modification shall be based on one or more of the specific considerations identified in Section III-22.

B. Risk Management

1% credit will apply for each Company approved CME hour of risk management completed, up to a maximum of 5% credit per year, or attendance at a Company approved seminar.

C. Deductible Credits

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer up to ($1M/$3M). Deductibles are subject to approval by the Company based on financial statements to be submitted by the insured and financial guarantees are required. The Company reserves the right to require acceptable securitization in the amount of the per claim and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

1. Individual Deductibles

Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:

~~Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:~~

INDEMNITY ONLY		INDEMNITY AND ALAE	
DEDUCTIBLE PER CLAIM		DEDUCTIBLE PER CLAIM	
$5,000	2.5%	$5,000	6.5%
$10,000	4.5%	$10,000	11.5%
$15,000	6.0%	$15,000	15.0%
$20,000	8.0%	$20,000	17.5%
$25,000	9.0%	$25,000	20.0%
$50,000	15.0%	$50,000	30.5%
$100,000	25.0%	$100,000	40.0%
$200,000	37.5%	$200,000	55.0%

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$250,000	42.0%	$250,000	58.0%

The following Individual Deductibles are available on a Per Claim/Aggregate Basis. Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:

~~C. Deductible Credits (Continued)~~

Indemnity Only Per Claim/Aggregate		Indemnity & ALAE Per Claim/Aggregate	
$5000/15,000	2.0%	$5000/15,000	5.5%
$10,000/30,000	4.0%	$10,000/30,000	10.5%
$25,000/75,000	8.5%	$25,000/75,000	19.0%
$50,000/150,000	14.0%	$50,000/150,000	29.5%
$100,000/300,000	24.0%	$100,000/300,000	43.0%
$200,000/600,000	36.0%	$200,000/600,000	53.5%
$250,000/750,000	40.0%	$250,000/750,000	56.5%

2. Group Deductibles

An optional deductible, which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year. When the organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below. Group deductible amounts apply to primary premium up to $1M/3M only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate	Number of Insureds				Maximum Credit
($000)	2-19	20-40	41-60	61-100	
5/15	.020	.018	.015	.012	$10,500
10/30	.038	.035	.030	.024	21,000
25/75	.084	.079	.070	.058	52,500
50/150	.145	.139	.127	.109	105,000
100/300	.234	.228	.216	.196	120,000
200/600	.348	.346	.338	.321	420,000
250/75 0	.385	.385	.381	.368	525,000

~~C. Deductible Credits (Continued)~~

The following Group Deductibles are available for Indemnity & ALAE.

Indemnity & ALAE Deductible Per Claim/Aggregate	Number of Insureds				Maximum Credit
($000)	2-19	20-40	41-60	61-100	
5/15	.029	.026	.021	.017	$12,750
10/30	.068	.063	.054	.043	25,500
25/75	.119	.112	.099	.082	63,750
50/150	.186	.179	.163	.140	127,500
100/300	.258	.252	.239	.216	255,000
200/600	.396	.394	.385	.366	510,000
250/75 0	.467	.467	.462	.446	637,500

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D. Experience Rating

This plan applies to physicians and surgeons medical professional liability risks contained in medical groups. As used in this plan, the term "risk" means the exposures of medical groups which have common management, a common and mutually agreed risk management program or a financial relationship among all members which encourages high levels of quality control and a reduction in liability claims.

On an optional basis, large risks with sufficiently credible loss experience may be loss-rated to develop an appropriate premium. To be eligible for loss rating, a group must have at least for the latest 10-year period and at least $100,000 in estimated annual premium.

The experience period will be the latest completed 10 years. If 10 years are not available, consideration will be given to at least 5 complete years.

Losses are developed to ultimate and trended to cost levels for the proposed policy year. Losses will be capped at $250,000 per loss.

The experience period does not include the 12-month period immediately prior to the effective date of the experience modification.

The experience rating modification is calculated using the following formula:

$$\text{Credibility} \times \frac{\text{Adjusted Actual Loss Ratio} - \text{Adjusted Expected Loss Ratio}}{\text{Adjusted Expected Loss Ratio}} = \text{Experience Mod.}$$

~~D. Experience Rating (Continued)~~

Since the experience rating plan is applied on an individual risk basis, the final impact of these changes varies by individual medical group based on risk size and loss experience by year. As a result, the anticipated overall rate impact due to the changes in the experience rating plan is indeterminable. However, the primary purpose of this plan and the revisions is to more accurately distribute the cost of insurance among eligible insureds.

E. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claim free. A schedule is provided in Section III-20.

F. Individual Risk Rating

A risk may be individually rated by submitting a filing to the Illinois Department of Insurance, in accordance with Section 155.18(b)(4) of the Illinois Insurance Code.

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The code allows us to modify classification rates to produce rates for individual risks. Modifications of classifications of risks may be based upon size, expense, management, individual experience, location or dispersion of exposure, and shall apply to all risks under the same or substantially the same circumstances or conditions. We must list the standards by which variations in hazards or expense provisions are measured, in order to determine that a specific risk is so different in hazard/expense that it warrants individual rating.

VI. MODIFIED PREMIUM COMPUTATION

A. Slot Rating

1. Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.

2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

~~3.~~ Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Underwriting Vice President.

3.

B. Requirements for Waiver of Premium for Extended Reporting Period Coverage.

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

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3. The Reporting Period is unlimited.

C. Blending Rates

A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.

D. Per Patient Visit Rating

1. Standard Claims Made coverage for group practices is available, at the Company's option, on a per patient visit basis rather than on an individual physician basis. Coverage is provided on a shared or individual physician limit basis.

2. The number of patient visits equivalent to a physician year is 2500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour.

3. The applicable medical specialty rate is divided by the equivalent patient visits resulting in the patient visit rate to be applied to the visits projected for the policy period. The product of the patient visit rate and the projected visits results in the indicated manual premium.

4. The annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion.

5. Premium modifications for new physician, part time, teaching, risk management or claim free credit cannot be used in conjunction with this rating rule.

VII. PREMIUM COMPUTATION DETAILS

A. Classifications

1. Applicable to Standard Claims-Made Programs.

2. The following classification plan shall be used to determine the appropriate rating class for each individual insured.

~~2.~~

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PHYSICIANS & SURGEONS

CLASS 1

Allergy/Immunology
Forensic Medicine
Occupational Medicine
Otorhinolaryngology-NMRP, NS
Physical Med. & Rehab.

Public Health & Preventative Med
Other, Specialty NOC

CLASS 2

Dermatology
Endocrinology
Geriatrics
Ophthalmology-NS
Pathology
Podiatry, No Surgery
Psychiatry
Rheumatology
Other, Specialty NOC

CLASS 3

Pediatrics-NMRP
Other, Specialty NOC

CLASS 4

Diabetes
Family Practice-NMRP, NS
General Practice-NMRP, NS
General Surgery-NMRP
Hematology
Industrial Medicine
Neurosurgery-NMRP, NMajS
Nuclear Medicine

Oncology
Ophthalmic Surgery
Oral/Maxillofacial Surgery
Orthopaedics-NMRP, NS
Radiation Oncology
Thoracic Surgery-NMRP, NS
Other, Specialty NOC

CLASS 5

Cardiovascular Disease-NMRP, NS
Infectious Disease
Nephrology-NMRP
Other, Specialty NOC

CLASS 6

Gynecology-NMRP, NS
Internal Medicine-NMRP
Certified Registered Nurse Anesthetist
Other, Specialty NOC

CLASS 7

Anesthesiology
Nephrology-MRP
Podiatry, Surgery
Pulmonary Diseases
Radiology-NMRP
Other, Specialty NOC

CLASS 8

Cardiac Surgery-MRP, NMajS
Cardiovascular Disease-Spec. MRP
Gastroenterology
General Surgery-MRP, NMajS
Hand Surgery-MRP, NMajS
Internal Medicine-MRP
Neurology
Orthopaedics-MRP, NMajS
Otorhinolaryngology-MRP, NMajS

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Pediatrics-MRP
Radiology-MRP
Urology-MRP, NMajS
Vascular Surgery-MRP, NMajS
Other, Specialty NOC

CLASS 9

Family Practice-MRP, NMajS
General Practice-MRP, NMajS
Other, Specialty NOC

CLASS 10

Neurosurgery-MRP, NMajS
Urological Surgery
Other, Specialty NOC

CLASS 11

Cardiovascular Disease-MRP
Colon Surgery

Emergency Medicine-NMajS, prim
Gynecology/Obstetrics-MRP,
Nmaj
Otorhinolaryngology; No Elective
Plastic
Radiology-MajRP
Other, Specialty NOC

CLASS 12

Emergency Medicine-MajS

Family Practice-not primarily MajS
General Practice-NMajS, prim
Gynecological Surgery
Hand Surgery
Head/Neck Surgery
Otorhinolaryngology; Head/Neck

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Other, Specialty NOC

CLASS 13

General Surgery
Other, Specialty NOC

CLASS 14

Neonatology
Otorhinolaryngology; Other Than Head/Neck
Plastic Surgery
Other, Specialty NOC

CLASS 15

Orthopaedic Surgery s/o Spine
Other, Specialty NOC

CLASS 16

Cardiac Surgery
Thoracic Surgery
Vascular Surgery
Other, Specialty NOC

CLASS 17

Obstetrical/Gynecological Surgery
Other, Specialty NOC

CLASS 18

Neurosurgery-No Intracranial Surgery
Orthopaedic Surgery wSpine
Other, Specialty NOC

CLASS 19

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Neurosurgery
Other, Specialty NOC

MEDICAL PROCEDURE DEFINITIONS

NMRP: NOMINAL MINOR RISK PROCEDURE

NS: NO SURGERY

NOC: NOT OTHERWISE CLASSIFIED

NMAJS: NO MAJOR SURGERY

MRP: MINOR RISK PROCEDURES

MAJRP: MAJOR RISK PROCEDURES

NON PHYSICIAN HEALTH CARE PROVIDERS

Class X

Fellow, Intern, Optician, Resident, Social Worker

Class Y

Optometrist, Physical Therapist, X-Ray and Lab Technicians

Class Z

Nurse Practitioner – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Physician Assistant – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Psychologist – Class 1

Certified Registered Nurse Anesthetist
Shared Limits – 20% times Anesthesiologist rate
Separate Limits – 25% times Anesthesiologist rate

Certified Nurse Midwife – No complicated OB or surgery
Shared Limits – Not available

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Separate Limits – 50% of OB/GYN rate

B. Territory Definitions

TERRITORY 1 COUNTIES

Cook, Jackson, Madison, St. Clair and Will

TERRITORY 2 COUNTIES

Lake, Vermillion

TERRITORY 3 COUNTIES

Kane, McHenry, Winnebago

TERRITORY 4 COUNTIES

DuPage, Kankakee, Macon

TERRITORY 5 COUNTIES

Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle, Randolph

TERRITORY 6 COUNTIES

Grundy, Sangamon

TERRITORY 7 COUNTIES

Peoria

TERRITORY 8 COUNTIES

Remainder of State

C. Standard Claims Made Program Step Factors

First Year:	25%
Second Year:	50%
Third Year:	78%
Fourth Year:	90%
Fifth Year (Mature):	100%

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Mature Rates for Physicians and Surgeons (Claims-made):

$1,000,000 / 3,000,000

Class	Medical Specialty	Terr 1	Terr 2	Terr 3	Terr 4	Terr 5	Terr 6	Terr 7	Terr 8
1	Allergy/Immunology	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Forensic Medicine	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Occupational Medicine	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Otorhinolaryngology-NMRP, NS	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Physical Med. & Rehab.	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Public Health & Preventative Med	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Other, Specialty NOC	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
2	Dermatology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Endocrinology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Geriatrics	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Ophthalmology-NS	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Pathology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Podiatry, No Surgery	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Psychiatry	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Rheumatology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Other, Specialty NOC	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
3	Pediatrics-NMRP	22,579	20,473	19,422	17,316	16,261	14,155	10,998	12,049

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3	Other, Specialty NOC	22,579	20,473	19,422	17,316	16,261	14,155	10,998	12,049
4	Diabetes	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Family Practice-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	General Practice-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	General Surgery-NMRP	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Hematology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Industrial Medicine	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Neurosurgery-NMRP, NMajS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Nuclear Medicine	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Oncology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Ophthalmic Surgery	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Oral/Maxillofacial Surgery	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Orthopaedics-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Radiation Oncology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Thoracic Surgery-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Other, Specialty NOC	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
5	Cardiovascular Disease-NMRP, NS	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Infectious Disease	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Nephrology-NMRP	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Other, Specialty NOC	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
6	Gynecology-NMRP, NS	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
6	Internal Medicine-NMRP	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
6	Other, Specialty NOC	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
7	Anesthesiology	37,159	33,595	31,813	28,231	26,467	22,903	17,557	19,339
7	Nephrology-MRP	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Podiatry, Surgery	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Pulmonary Diseases	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Radiology-NMRP	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339

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7	Other, Specialty NOC	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
8	Cardiac Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Cardiovascular Disease-Spec. MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Gastroenterology	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	General Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Hand Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Internal Medicine-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Neurology	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Orthopaedics-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Otorhinolaryngology-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Pediatrics-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Radiology-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Urology-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Vascular Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Other, Specialty NOC	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
9	Family Practice-MRP, NMajS	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
9	General Practice-MRP, NMajS	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
9	Other, Specialty NOC	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
10	Neurosurgery-MRP, NMajS	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
10	Urological Surgery	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
10	Other, Specialty NOC	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
11	Cardiovascular Disease-MRP	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Colon Surgery	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Emergency Medicine-NMajS, prim	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Gynecology/Obstetrics-MRP, Nmaj	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439

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	Otorhinolaryngology; No Elective								
11	Plastic	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Radiology-MajRP	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Other, Specialty NOC	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
	Emergency								
12	Medicine-MajS	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Family Practice-not primarily MajS	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	General Practice-NMajS, prim	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Gynecological Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Hand Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Head/Neck Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Otorhinolaryngology; Head/Neck	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Other, Specialty NOC	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
13	General Surgery	88,999	80,251	75,877	67,129	62,755	54,007	40,885	45,259
13	Other, Specialty NOC	88,999	80,251	75,877	67,129	62,755	54,007	40,885	45,259
14	Neonatology	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Otorhinolaryngology; Other Than Head/Neck	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Plastic Surgery	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Other, Specialty NOC	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
	Orthopaedic								
15	Surgery s/o Spine	101,956	91,915	86,893	76,849	71,827	61,783	46,717	51,739
15	Other, Specialty NOC	101,956	91,915	86,893	76,849	71,827	61,783	46,717	51,739
16	Cardiac Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Thoracic Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Vascular Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Other, Specialty NOC	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839

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17	Obstetrical/Gynecological Surgery	124,636	112,324	106,168	93,856	87,703	75,391	56,923	63,079
17	Other, Specialty NOC	124,636	112,324	106,168	93,856	87,703	75,391	56,923	63,079
18	Neurosurgery-No Intracranial Surgery	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
18	Orthopaedic Surgery wSpine	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
18	Other, Specialty NOC	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
19	Neurosurgery	205,636	185,224	175,018	154,606	135,400	123,988	93,373	103,576
19	Other, Specialty NOC	205,636	185,224	175,018	154,606	135,400	123,988	93,373	103,576

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D. Mature Rates for non Physician Health Care Providers

Class X equals 0% of the Class 1 Physician/Surgeon rate, for shared limits; 10% of Class 4 rate for separate limits.

Class Y equals 0% of the Class 1 Physician/Surgeon rate, for shared limits; 15% of the Class 4 rate for separate limits.

Class Z equals 10% of the Class 1 Physician/Surgeon rate for shared limits; 25% of Class 1 Physician/Surgeon rate for separate limits.

Note any non-Physician Health Care Providers in Classes X, Y, or Z with exposure in the Emergency Room will require the referenced factor times the Class 11 rate.

E. Liability Limits Factors:

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Limits		
	Physicians	Surgeons
500/1.0	.719	.719
1M/3M	1.0	1.0
2M/4M	1.36	1.55
3M/5M	1.52	1.73

F. Extended Reporting Period Coverage Factors:

1. The following represents the tail factors to be applied to the annual discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

Year	Factor
1st	3.30
2nd	3.15
3rd	2.40
4th	2.00

2. For First Year Claims Made step, the corresponding factor above is applied pro-rata. For Second Year and all years of maturity, the corresponding factor above is applied to the ~~expiring premium.~~ last year's (365 days) annualized premium from the date of cancellation.

~~F. Extended Reporting Period Coverage Factors (Continued):~~

3. The Reporting Period is unlimited.

G. Shared Limits Modification:

Not available.

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H. Policy Writing Minimum Premium:

Physicians & Surgeons - $500.

I. Policy Writing Minimum Premium:

Non-Physician Healthcare Providers - $500

J. Separate Limits for Non-Physician and Surgeon Healthcare Providers Modification:

Class X: 20% of Class 1
Class Y: 25% of Class 1
Class Z: 35% of Class 1

K. Premium Modifications

~~For individual physicians and surgeons:~~

~~1. Part Time Physicians & Surgeons – 30%~~
~~2. Physicians in Training – 1st Year Resident 50%; Resident 40%; Fellow 30%.~~
~~3. Locum Tenens – no premium, subject to prior underwriting approval~~
~~4. New Physicians & Surgeons – 30% for the first two years of practice~~
~~5. Physician Teaching Specialists – Non-surgical 50%; Surgical 40%.~~
~~6. Physician's Leave of Absence – full suspension of insurance and premium for up to one year, subject to underwriting approval~~

For individual physicians and surgeons:

1. Part Time Physicians & Surgeons – 30%
2. Physicians in Training – 1st Year Resident – 50%, Resident – 40%, Fellow – 30%
3. Locum Tenens – no premium, subject to prior underwriting approval.
4. New Physicians & Surgeons – 30% for the first two years of practice.
5. Physician Teaching Specialists – Non-surgical – 50%, Surgical – 40%
6. Physician's Leave of Absence – full suspension of insurance and premium for up to one year, subject to underwriting approval.

L. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit based on the following schedule:

1. If claim free for 3 years but less than 5 years, a 5% credit shall be applied at the policy inception date. ~~[indented over]~~

2. If claim free for 5 years but less than 8 years, a 10% credit shall be applied at the policy inception date.

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3 If claim free for 8 years but less than 10 years, a 15% credit shall be applied at the policy inception date.

4. If claim free for 10 years or more, a credit of 20% shall be applied at the policy inception date.

A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

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M. Schedule Rating (not to be used in conjunction with Loss Rating)

1. Historical Loss Experience +/- 25%	The frequency or severity of claims for the insured(s) is greater/less than the expected experience for an insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.
2. Cumulative Years of Patient Experience. +/- 10%	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.
3. Classification Anomalies. +/-_ 25%	Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures. +/- 10%	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.
6. Number /Type of Patient Exposures. +/- 10%	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.
7. Organizational Size / Structure. +/- 10%	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
g. Medical Standards, Quality & Claim Review. +/- 10%	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees mat meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.
9. Other Risk Management Practices and Procedures. +/- 10%	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & Credentialing. +/- 10%	The insured(s) exhibits greater/less than normal participation and support of such activities.
11. Record - Keeping Practices. +/- 10%	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.

Maximum Modification	+ / - 50%

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N. Deductible Credits

See V.C in Section III-4.

O. Experience Rating

See V.D in Section III-7.

P. Slot Rating for groups, subject to Underwriting

See VI.A in Section III-8.

~~Q. Mandatory Quarterly Payment Option.~~

~~For medical liability insureds whose annual premiums total $500 or more, the plan must allow the option of quarterly payments.~~

1. ~~An initial payment of no more than 40% of the estimated total premium due at policy inception;~~
2. ~~The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;~~
3. ~~No interest charges;~~
4. ~~Installment charges or fees of no more than the lesser of 1% of the total premium or $25, whichever is less; and~~
5. ~~A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.~~

~~Non-Mandatory Quarterly Payment Option.~~

1. ~~For medical liability insureds whose annual premiums are less than $500, insurers may, but are not required to, offer quarterly installment , premium payment plans.~~
2. ~~For insureds who pay a premium for any extension of a reporting period, insurers may, but are not required to, offer quarterly installment, premium payment plans.~~
3. ~~If an insurer offers any quarterly payments under this sub-section, (g) Non-Mandatory Quarterly Payment Options, they must be offered to all medical liability insureds.~~

~~Quarterly installment premium payment plans subject to (R) above shall be included in the initial offer of the policy, or in the first policy renewal. Thereafter, the insurer may, but need not, re-offer the payment plan, but if an insured requests the payment plan at a later date, the insurer must make it available.~~

-END OF SECTION III-

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SECTION IV

Medicus Secured Protection Program

1. OVERVIEW

Medicus Insurance Company (hereinafter "Company") offers individual physician or group premium modifications to physicians who fail to meet standard rating criteria for premium computation under Section III of Medicus Insurance Company's Manual in order to afford physicians every reasonable opportunity to remain insured with an admitted standard insurer. The Secured Protection Program is an amendment to the Medicus Insurance Company Manual currently approved in the state and is incorporated by reference in Section IV. The Medicus Secured Protection Program (SPP) may be offered to new and renewal policies falling into this category. Qualifying circumstances include but are not limited to:

DEA License Suspension
Professional Misconduct
Successful Completion of Chemical Dependency Program
Adverse Claims Experience (Severity and/or Frequency)
Proctorship
Medical Board Sanctions or Fines
Unusual Practice Characteristics
Physical or Mental Health Impairments
Bare Exposure Period
Cosmetic Procedures Outside Scope of Formal Training

The majority of renewal business falling into this category is a result of higher than expected frequency and severity of claims. Coverage is offered to physicians who fall outside the parameters of the standard Medicus program but do not warrant coverage in the non- standard market. Insureds who have unsuccessfully appealed an underwriting decision of non-renewal are also eligible for coverage under this program.

2. Applicant Referral Criteria:

A. Eligibility-New Business

In lieu of declining a physician or group, the outlined surcharges on pages 5 through 10 of the Medicus Insurance Company Manual Section IV part 8. Medicus Secured Protection Program Rating Formula may be applied for a physician or group that does not meet the minimum underwriting guidelines established by the Company's Manual Section III.

B. Eligibility-Renewal Business

In lieu of nonrenewing a physician or group, the following surcharges may be applied for:

1. A physician or group whose claim severity and/or frequency for its specialty exceeds an actuarially expected standard; or

2. A physician or group for whom underwriting information (other than claim severity and/or claim frequency) has been developed that does not meet the minimum underwriting guidelines established by the Company's

Manual Section III.

Surcharges are subject to the point ranges set forth on the Points Evaluation Worksheet (see pg. 10), surcharges of 50% to 400% will be applied as a percentage of the premium. Case reserve amounts on pending claims are adjusted pursuant to underwriting guidelines.

The Company will grant individual consideration to New Solo Applicants (i.e. those not members of a group). A solo physician may not be appropriate for the SPP.

3. LENGTH OF INSURED'S REHABILITATION

Each Insured accepted in the SPP shall be surcharged up to a maximum of 3 years under the SPP, subject to meeting minimum requirements of rehabilitation.

4. RATING APPROACH

Premium is calculated by applying the rate per physician on the rate pages from the Medicus Manual under Section III, in accordance with each individual's medical classification, territory designation and standard claims made program step factors. This 'base rate' or un-discounted premium is then multiplied by the appropriate surcharge amount calculated on the Points Evaluation Worksheet (see pg. 10). No other surcharges will apply concurrently with a physician or group category surcharge. Surcharges range from +50% to +400%. If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the insured has been claims free under the current Medicus Insurance Company Manual Section III part VII (6.) Claim Free Credit Program.

5. UNDERWRITING

Key factors considered in physician evaluation for the Medicus Secured Protection Program (SPP) other than bare exposure is the probability and degree of rehabilitation. Underwriting will evaluate the nature of each claim to determine if it represents a pattern of poor judgment. Further, additional consideration is given to a physician affiliated with a group that can provide additional support, influence, and/or oversight. This is also due in part to the Medicus philosophy and requirement that physicians practicing together must be insured by a common carrier (all or nothing rule). If the group otherwise has good experience, Medicus strives to work with the group and the physician to reach a mutually beneficial agreement. The goals of the SPP are that:

1. A physician returns to or stays in the standard Medicus program at a surcharge,
2. After three years becomes eligible to qualify for coverage under the standard rating rules, and
3. An entire group does not become uninsurable under the standard program due to the loss experience of one or two physicians.

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It is foreseeable that a physician or physician group must be non-renewed based on an underwriting assessment that a group would be unable to resolve persisting issues resulting in continued losses within the 3-year period.

A. Coverage Modifications

1. The only limits available to physicians in the program are $1 million/$3 million or state minimum requirement.

2. The applicable corporate limit of any physician in the SPP is a shared limit. No separate limit is available (See SPP01 Secured Protection Plan Endorsement).

3. Policies may contain specific procedure limitation exclusions and other exclusions, (See Medicus Form A013 (Exclusion of Procedure Endorsement)) such as consent to settle, which will require the written agreement by the applicant prior to policy issuance.

4. Physicians may be required to carry an indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) deductible at the discretion of the underwriter not to exceed a $5,000 per physician per claim deductible with a $15,000 deductible annual aggregate.

B. Consent to Settle

Physicians insured under the Medicus Secured Protection Program (SPP) are issued policies with endorsements restricting consent to settle. While insured in the SPP, consent to settle lies with the Company. A physician is expected to be rehabilitated and to return back to the standard program where he/she will regain the right to consent.

C. Impaired Physicians

An impaired physician is identified as one who is monitored by the physician's resident state's Physician Health Program, medical board or similar organization. Physicians may be required to go through a formal recovery program depending upon the degree/nature of the chemical dependency. Upon discharge from an approved program, the physician signs an agreement for regular monitoring, including random urinalyses. Medicus will not insure physicians who do not allow us to obtain information from their treatment facility. This program also assists physicians suffering from mental disorders.

D. Prior Acts

Physicians entering the Medicus Secured Protection Program (SPP) with at least 2 years of prior acts coverage from the standard Medicus program shall carry over prior acts coverage as per the Medicus Insurance Company Manual Section I part XIV Prior Acts Coverage. Physicians with less than 2 years of

prior acts coverage with Medicus Insurance Company will receive careful consideration of physician or group details before offering prior acts coverage.

E. Imposed Deductibles

Deductibles may apply either to indemnity only or indemnity and claim expenses (Allocated Loss Adjustment Expenses (ALAE)) not to exceed $5,000 per claim with a $15,000 deductible annual aggregate. An imposed deductible may be endorsed to address claims frequency. All deductibles require financial guarantees.

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6. PHYSICIAN OR GROUP MANAGEMENT

It will be mandatory for all insureds in the Medicus Secured Protection Program (SPP) to successfully complete 10 hours of approved CME programs each year. SPP insureds are eligible for Physician or Group Management discounts offered under Medicus Insurance Company Manual Sections III part III (K) Premium Modifications.

Approved programs will include, but are not limited to, the following physician or group management and quality assurance topics:

- Specialty and Procedure Specific Programs
- I've experienced a Maloccurance
- The Best Deposition You Can Give
- EMR Vulnerabilities
- Online Offerings through MedRisk or other approved programs
- Use of medication flow sheet for patients taking multiple and or long term medication, use of system to assure physician review of all reports (lab and x-ray consultations, etc.)
- Having patient completed health history questionnaire and use of SOAP or similar charting systems in a consistent, organized chart format

7. INTERNAL LOGISTICS

All Medicus Secured Protection Program (SPP) insureds will be monitored through the Medicus Insurance Company Software (MIC4). These insureds will be distinguished by a unique identifier (SPP), and underwritten under the electronic version of the Frequency & Severity Claims Schedule (see page 8) and Point Evaluation Worksheet (see page SPP 10). Each program insured will be monitored on a quarterly basis. If deemed necessary by the underwriting manager, the physician may be required to have an onsite physician or group management review, continued drug testing, or extend proctorship at the expense of the physician.

8. MEDICUS SECURED PROTECTION PROGRAM RATING FORMULA

POINTS SCHEDULE A
Claims within the last 10 years from date of Report

A.	Frequency and Severity Claims Schedule	Points from Schedule
B.	No Claims reported in the past five full years	-100

Drug or Alcohol Impairment- Health

A.	Has experienced drug, alcohol, or mental illness problems more than 5 years ago	50
B.	Has experienced drug, alcohol, or mental illness problems with the past 5 years	75
C.	Currently in treatment for unresolved substance abuse	150
D.	Any relapse with in the past 5 years	150
E.	Physical or mental impairment that impacted physician's ability to practice medicine safely.	100

Government Agency Actions

A.	Medical license in any state has been revoked.	150
B.	Medical license in any state has been suspended.	100
C.	Medical license has been placed on probation with restrictions on the type of services he or she can provide	75
D.	Medical license has been placed on probation for more than 5 years	75
E.	Medical license has been placed on probation for 1 to 5 years	50
F.	Medical license is under investigation	40
G.	Public letter of reprimand, fine, citation, etc.	50
H.	Failure to report license investigation as required by affirmative duty language in policy.	50
I.	During the preceding 5 year, DEA license has been revoked suspended or issued with special terms or conditions, or license has been voluntarily surrendered or not renewed, other than normal nonrenewal license substantiated by physician.	100
J.	Has been convicted or indicted of a criminal act, or has been found to be in a violation of a civil statute, per event.	
	Medically Related	
	Within 5 years	100
	More than 5 years	50
K.	Medicare/Medicaid investigation	40
L.	Loss of Medicare/Medicaid Privileges	50
M.	Loss of any health insurance provider privileges	50

Note: Items A,B,C,D,E,F,G and H - only applies per event -i.e., highest point value.

Inappropriate Patient Contact

A.	Proven with a single patient.	75
B.	Proven with more than one patient.	150
C.	Alleged with one or more patients.	50

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POINTS SCHEDULE A (cont.)

Medical Education

A.	Attended more that one medical school or a residency program due to actual or planned disciplinary action	50
B.	Residency complete at two or more facilities	50
C.	Started, but did not complete, a full residency program.	50
D.	Did not begin a residency.	50
E.	Has never received board certification	50

Medical Records

A.	Records alterations with material change and intent	150
B.	Records alterations not a material change to records just cleaning up	25
C.	Generally poor record keeping.	50

Informed Consent

A.	Incomplete consent obtained.	25
B.	Lack of Informed consent.	50

Privileges - Any State

(Hospital, Surgery Center, Etc.)

A.	Privileges have been involuntarily restricted, or restricted by negotiation in the past 10 years (per event).	50
B.	Privileges have been suspended in the past 10 years (per event).	100
C.	Privileges have been revoked in the past 10 years (per event).	150
~~E~~D.	Has been notified by facility of its intent to:	
	Restrict Privileges	30
	Suspend Privileges	50
	Revoke Privileges	100
	Note: Only applies per Occurrence -i.e. highest point value	
~~F~~E.	No Privileges at any facility	100
~~G~~F.	Currently undergoing peer review.	75
~~H~~G.	Notice of peer review received	50

Procedures

A.	Is performing a medical procedure that is considered experimental but not directly dangerous	15
B.	Is performing a medical procedure that is in violation of policy exclusions	50
C.	Is performing a procedure(s) not usual and customary to his/her medical specialty.	50
D.	Is performing a medical procedure that is in violation of policy exclusion and is considered dangerous.	150
E.	Is performing a procedure(s) outside his/her medical specialty.	100
F.	Is performing high physician or group procedures within his/her medical specialty	100

Patient Safety / Physician or group Management

A.	Mandatory patient safety/physician or group management previously recommended and Failure to comply with physician or group management requirements.	100

B.	Mandatory patient safety/physician or group management previously recommended and insured had initial compliance but no follow through.	75
	Gaps in Medical Practice	
A.	Gaps in medical practice of 6-months to 1-year duration.	50
B.	Gaps in medical practice of 1-2 years duration.	100
C.	Gaps in medical practice greater than 2 years.	150
	Payment History	
A.	Two or more late payments within the last three years.	100
B.	Two or more cancellations for non-payment of premium within the last three years.	150
	Other	
A.	Uncooperative in Claims Handling	150
B.	Patient Load:	
	For Surgeons, 61-99 patients per week	50
	For Surgeons, 100 or more patients per week	100
	For all others, 101-149 patients per week	50
	For all others, 150 or more patients per week	100
C.	Advertising: If insured advertises his/her services on TV, newspapers, billboards or radio	25
D.	Uses collection agency that can file suit without insured's written consent.	25
E.	Previous insurance history (bare, insolvent prior insurer or non-renewed).	100
F.	Claim experience of Associates, Partners or Corporation:	
	If one member with claim(s)	75
	If more than one member with claim(s)	100
	Favorable experience of group as a whole	-150
G.	For each claim or suit in which the physician breached the standard of care:	
	Mixed Reviews	50
	All Negative Reviews	100
	Admitted or Clear Liability	100
H.	For two or more claims, suits or incidents arising out of the same or similar procedures or treatments.	50
I.	Claim is too early in discovery period:	
	Surgical Class	-100
	Non-Surgical Class	-50
J.	For each claim or suit in which expert reviewers state the insured met the standard of care:	
	Surgical Class	-150
	Non-Surgical Class	-100
K.	High-physician or group surgical patient selection.	150
L.	Reinstatement of nonrenewal due to company election	150
M.	Loss Ratio in excess of 500%.	150
N.	Loss Ratio less than 100%.	-100
O.	Discrepancies between application answers/documents and verification	150

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FREQUENCY AND SEVERITY CLAIMS SCHEDULE

Insured: _____ Policy#: _____

(If Applicable)

Effective Date: _____ Review Date: _____

Claims Without Indemnity		
ALAE		
From:	To:	Claim Score
$5,001	$25,000	1
$25,001	$50,000	2
$50,001	$100,000	3
$100,001	& up	4

Claims With Indemnity		
Indemnity + ALAE		
From:	To:	Claim Score
$1	$25,000	4
$25,001	$50,000	5
$50,001	$100,000	6
$100,001	$250,000	7
$250,001	$500,000	8
$500,001	$750,000	9
$750,001	$1,000,000	11
$1,000,001	& up	13

	Claimant Name	Report Date	Indemnity	ALAE	Total	Claim Score
Claim # 1		/ /	$	$		
Claim # 2		/ /	$	$		
Claim # 3		/ /	$	$		
Claim # 4		/ /	$	$		
Claim # 5		/ /	$	$		
Claim # 6		/ /	$	$		
Claim # 7		/ /	$	$		
Claim # 8		/ /	$	$		
Claim # 9		/ /	$	$		
Claim # 10		/ /	$	$		

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Total: _____

Completed by:_____ Approved by:_____

Frequency and Severity Claims Schedule (Continued)

Total Claim Score	Low Frequency Specialties No. of Years w/MIC 0 - 2	3 - 5	6 - 8	9 & up
2	75	50	30	20
3	100	75	55	45
4	125	100	80	70
5	150	125	105	95
6	175	150	130	120
7	200	175	155	145
8	225	200	180	170
9	250	225	205	195
10	275	250	230	220
11	300	275	255	245
12	325	300	280	270
13	350	325	305	295
14	375	350	330	320
15	400	375	355	345

Total Claim Score	High Frequency Specialties ** No. of Years w/MIC 0 - 2	3 - 4	5 - 6	7 & up
3	75	50	30	20
4	100	75	55	45
5	125	100	80	70
6	150	125	105	95
7	175	150	130	120
8	200	175	155	145
9	225	200	180	170
10	250	225	205	195
11	275	250	230	220
12	300	275	255	245
13	325	300	280	270
14	350	325	305	295
15	375	350	330	320

(1) As of Review Date.
(2) Add 25 points for each Total Claim Score above 15.

** Emergency Medicine, General Surgery, Gynecology, Neurosurgery , Obstetrics & Gynecology, Orthopedic Surgery, Plastic Surgery, Thoracic Surgery and Urology

Points Evaluation Worksheet

Insured: _____ Policy#: _____

Effective Date: _____ (If Applicable) Review Date: _____

Criteria	Points
Claims	
Frequency	
Drug or Alcohol Impairment – Health	
Government Agency Actions	
Inappropriate Patient Contact	
Medical Education	
Informed Consent	
Privileges – Any State	
Procedures	
Physician or group Management	
Gaps in Coverage	
Other	
Total Points:	

Ranges & Surcharges

Point Range	Surcharge
0 – 100	0%
101-130	40%
131 – 160	45%
161 – 190	50%
191 – 210	55%
211 – 250	60%
251 – 280	70%
281 – 300	80%

Point Range	Surcharge
301 – 325	90%
326 – 350	100%
351 – 370	125%
371 – 390	150%
391 – 410	175%
411 – 430	200%
431 – 450	225%
451 – 470	250%

Point Range	Surcharge
471 – 490	275%
491 – 510	300%
511 – 530	325%
531 – 550	350%
551 – 570	375%
571 – 590	400%
591+	Nonrenew

Comments: _____

Completed by: _____ Approved by: _____

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